DOCUMENT RESUME

ED 097 555 CE 002 327

AUTHOR	Hornback, May, Ed.
TITLE	Health Maintenance Organization: Concept and Functions. Conference Proceedings.
INSTITUTION	Wisconsin Univ., Madison, Univ. Extension.
SPONS AGENCY	Public Health Service (DHEW), Arlington, Va.
PUB DATE	72
NOTE	79p.; Proceedings of a Conference on Health Maintenance Organizations: Concept and Functions (Madison, Wisconsin, September 1971)
EDRS PRICE	MF-$0.75 HC-$4.20 PLUS POSTAGE
DESCRIPTORS	*Community Health Services; Community Organizations; Community Services; *Conference Reports; *Delivery Systems; Educational Improvement; Educational Innovation; Futures (of Society); Health Needs; Health Services; Medical Education; Medical Services; Nurses; *Nursing; Role Perception
IDENTIFIERS	*Health Maintenance Organizations; HMOs

ABSTRACT

The proceedings published in the document are the outcomes from a conference to consider the role of professional nursing in relation to health maintenance organizations (HMOs) as one possible way to improve health care delivery. Emphasis is placed on strategies underlying the HMO concept and reviewing and extending understanding of factors which influence accessibility to and effective delivery of health care. Implications for nursing service and nursing education in a variety of settings are considered. Included in the document are: five presentations on these themes; participants' responses to a pretest and a posttest on concepts of HMOs; five group work reports discussing the conference themes; and several pages of questions for and answers from group work as developed by individual enrollees. Faculty, speakers, guests, and conferees are listed. (AJ)

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CONFERENCE PROCEEDINGS

HEALTH MAINTENANCE ORGANIZATION: CONCEPT AND FUNCTIONS

Edited by
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CE 002 327

Department of Nursing, Health Sciences Unit, University of Wisconsin--Extension
Under a Grant from the Public Health Services, United States Department of Health, Education, and Welfare

1972

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PREFACE

The delivery of health care is a problem which is of increasing concern to consumers and health professionals alike. Resolution of the problem is long overdue. The time for philosophizing about it is long past. Societal changes and technological advances have widened the branch between new-found knowledge and the points of application from a gap to a chasm.

The public has been dismayed at the rising costs of illness and disillusioned by the waiting time for health care attention. The traditional system of health care has obviously not been responsive to the needs of a changing, expanding society. Operating on a cure rather than preventive care orientation, health professionals have been actively treating the ill while passively espousing the importance of health maintenance.

The proceedings published here are the outcomes from a conference to consider the role of professional nursing in relation to health maintenance organizations (HMOs) as one possible way to improve health care delivery. Emphasis is placed on strategies underlying the HMO concept and reviewing and extending understanding of factors which influence accessibility to and effective delivery of health care. Implications for nursing service and nursing education in a variety of settings are considered.

The conference was held at The Wisconsin Center on the University of Wisconsin campus in Madison, on September 15, 16, and 17, 1971, and was supported by a training grant from the Public Health Service of the United States Department of Health, Education, and Welfare. Nurses residing or practicing in its Region V, namely Illinois, Indiana, Michigan, Ohio, Minnesota, and Wisconsin, who are in leadership positions in institutions and agencies attended.

The opening day of the conference was an interdisciplinary effort and was attended by representatives from other health disciplines besides nurses. Cooperating groups included the Health Planning Council, Inc., Wisconsin Dietetic Association, Wisconsin Hospital Association, Wisconsin Nurses Association, Wisconsin Pharmaceutical Association and Wisconsin Regional Medical Program, Inc.

If nursing and nurses are truly committed to bettering the quality of life through improved health care, the cues and clues provided for the nursing role merit your serious consideration. The assistance, guidance, and interest of all those whose names appear in the following pages are gratefully acknowledged. The work and thoughts of many are

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compiled in this publication. The poor, the aged, people in rural areas, the alcoholic, the convicted and others suffering from a lack of optimal health care may benefit as nursing moves forward to act on the concerns identified at the conference.

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INTRODUCTION TO THE CONFERENCE

Health Maintenance Organizations*

William L. Blockstein, Ph.D.
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This conference, supported by the United States Department of Health, Education, and Welfare, has as purposes a discussion, some considerations and the dissemination of information about the Health Maintenance Organization concept to health professionals representing a vari ty of disciplines not only in the Wisconsin community but also from H.E.W.'s Region Five. The specific objectives for the program are to develop a knowledge of the HMO, its evolution and concept for health care delivery. Having done this, we will consider functions in preventing and treating illness, and understanding of evolving and changing roles of health professionals and the steps involved in moving from a traditional system to an HMO system. Then, specific attention will be directed to an understanding of the HMO concept and its implications for nursing education and nursing service.

I want to share with you some material from a paper presented by Ann R. Somers of Princeton University.[1] She spoke in San Francisco Last September and described what she called Four Paradoxes of Modern Health Care. I think this provides thought for all of us as we consider the concept of Health Maintenance Organization.

Paradox #1. The Modern Patient

The average patient today is richer, better educated, longer-lived, and less disease-ridden than ever before. At the same time, thanks to his longer lifespan, the frequency of chronic disease, his increasing education, income, and expectations with respect to health and health care, he needs and demands more care than ever before. This applies both to the affluent majority and the poor minority. He is increasingly critical of existing health care institutions, and by whatever means he can command, in order to get what he thinks he needs.

Paradox #2. The Modern Physician

There are more and better-trained doctors than ever before performing many near-miracles, seeing more patients,

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*Prepared for Delivery, Conference of Health Maintenance Organizations: Concept and Functions, September 15, 1971, University of Wisconsin-Madison.

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earning more money, and with a heartening infusion of new humanism-not only among young doctors and medical students but even in the top ranks of organized medicine-to balance the former preoccupations with scientific and entrepreneurial medicine. But the continuously increasing imbalance between supply and demand is creating tremendous pressures-both emotional and financial, resentment on the part of both doctors and patients, and public depreciation of the profession-a dangerous situation that could easily turn the new idealism into frustrated cynicism.

Paradox #3. The Modern Hospital

The hospital, which has emerged as the undisputed professional and technological center of the health care world, is also the nearest approximation yet achieved to a community health center. It still enjoys the confidence of most Americans as dramatically demonstrated by the overwhelming Congressional vote to override President Nixon's veto of the 1970 Hill-Burton bill. But this institution is prevented from playing the central coordinating role, which its position logically dictates, as a result of a combination of internal and external contradictions.

Internally, the hospital has not been able to resolve the deep-rooted conflict between medical staff and lay administration, resulting in diffuse management and numerous inefficiencies. Externally, the hospital in the evolving health care system is challenged both by those who would turn the clock back to preinstitutional medicine and by those who claim the center of the evolving system should not be the hospital but some type of separate primary care unit or a government authority. Forced to carry multiple and ever-growing responsibilities with these two major issues unresolved, the hospital's costs spiral ever upward and in turn add fuel to the fire of public criticism.

Paradox #4. Recent Developments in Financing

Thanks to the tremendous expansion of both public and private programs, the financial barrier to health care has been substantially removed for most Americans. The vast majority are now protected, to a greater or lesser degree, by one or more such programs. The providers have benefited at least as much. Incomes have been substantially augmented and collection problems greatly eased. Many exciting innovations, such as prepaid group practice which effectively ties together the financing and delivery mechanism, have emerged.

Yet, shortcomings in most of the programs (especially Medicaid and nongroup commercial insurance; the continuing gaps and duplications and, above all, the ever-rising provider costs-now reaching critical dimensions) have meant inability

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to provide comprehensive coverage and have resulted in continuing dissatisfaction on the part of both providers and consumers. In some states and communities where Medicaid and/or other programs have had to be cut back to save money, the political repercussions-combined with other explosive factors in the American city-have contributed to a crisis situation in the strictest meaning of the term.

I have described these four paradoxes as set forth by Professor Somers to welcome you and to challenge your thinking during the course of the day, and for the days ahead as you relate what you will learn to your individual and institutional practices.

Reference

[1] Somers, Ann R., "How To Plan for Future Roles," Challenge to Pharmacy in the 70's, J. B. Graber and D. C. Brodie, eds., United States Department of Health, Education, and Welfare (Washington, D.C., 1970), pp. 56-64.

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CONCEPT, ORGANIZATION, AND STRATEGIES OF HMOs

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Most of the concepts involved in the health maintenance strategy are not new. I think its significance lies in the fact that it is the first time that these ideas have been incorporated in any kind of comprehensive and hopefully internally consistent agenda for change in the nation's health delivery system.

While our Health Services Research Center was involved in the development of the health maintenance strategy for the Nixon Administration, many of the things that I say today are my ideas and those of our group and not those of the Administration. Our role at the onset was to try to answer two questions. We were asked, How can the health delivery system be improved, particularly from the standpoint of controlling inflation in health services and improving the distribution and availability of health services without destroying its good features? The second question was, How can the federal government trigger change without forcing the health industry into a kind of arbitrary organizational blueprint, based on some sort of centralized, inflexible control of health providers, and without eliminating consumer choice and the influence of consumers on health providers?

The health maintenance strategy tries to answer these questions. It is based on the idea that the federal government can stimulate the process of change, but it can do it best not by forcing it or by insisting that we adopt one particular pattern, but by devising a series of incentives to encourage change. We hoped to stimulate providers to voluntarily make needed improvements in the delivery system, while at the same time responding to consumer needs and demands. Only time can judge the wisdom of this course of action because, by electing to foster voluntary change, the federal government has chosen an evolutionary course, as opposed to a revolutionary one, towards the goal of quality health care for everyone at reasonable cost.

Many would say that the problems in the health system are much too profound to go through any evolutionary approach. Whereas the evolutionary approach is indeed a slower one, I would like to point out that, in outlining his national health strategy in February 1971 in a special message to Congress, President Nixon became the first American President ever to advocate specific and sweeping change in the way medical care was delivered and paid for. There have been many Presidents who have spoken in terms of national health insurance and new ways of financing medical care from public funds, but no one has been willing to say that this delivery system is at fault and it's got to be changed. In fact, the most recent health legislation, the RMP and the CHP's bills, actually prohibited changes of the kind set forth in the President's national health strategy. So, while the approach may be evolutionary, its objective is revolutionary. If it's achieved, the United States

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will become the first country in the world to successfully restructure its health delivery system.

We think in terms of the impact that national health insurance in Sweden, England, and so forth must have had in reshaping the effect on the health delivery system. In reality it hasn't. Medical care is organized and delivered in much the same way in those countries as it was at the time the national health insurance system was installed. And, in many ways, the price of installing national health insurance can be a commitment to do it the same old way. That was certainly one of the prices that was paid for Medicare. Early in the Medicare debate there was a question about paying hospital-based physicians through the hospital. This would be an encouragement to integrate the hospital with physicians, but it was cut out of the bill as being too revolutionary and too different from the normal pattern of health care. It represented a price for getting Medicare.

Now what is a Health Maintenance Organization? The term "Health Maintenance Organization" is a generic one-it is meant to describe any organized system of health care that provides a full range of health maintenance and treatment services to an enrolled population, a group of people who voluntarily enrolled with it in return for a fixed sum of money agreed upon in advance.

While they may vary in organizational structure, HMOs have three essential components: First of all, organizations deliver comprehensive health care as opposed to the present focus on individuals delivering services. Secondly, they deliver these services to a group of people who agree to get most of their medical care from the organization but agree to get it on a voluntary basis. And third, these organizations agree in advance as to what medical care is going to cost for each individual and they agree to deliver all of the medical care that the individual requires under the contract for that fixed price. Now I'd like to expand on this a little bit.

Most health maintenance organizations I think will be relatively large organizations, certainly larger than most of the firms that now deliver medical care in this country. Incidentally, I'm going to use words like firms and industry and so forth on purpose. I think that much of the mystic of medicine is wrapped up in the use of some words that are not applied to the economic system in general. The medical care system is a large economic system and, in fact, a $70 billion a year industry, the second largest industry in the United States. I think we might as well get used to the jargon of the economist as it's applied to medicine. It makes it a little easier to step back and be rather objective about it, rather than getting all tangled up in terms like doctor-patient relationship and so forth which are very important, but which may disguise a lot of rather rigid approaches to medical care that perhaps we have to re-examine.

At the present time medical care in this country is delivered by approximately 150,000 small firms. Most of these firms consist of a single physician and his office staff and many are engaged, as you know,

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in very highly specialized forms of medical practice. If HMOs become the dominant form of health delivery, we can expect that the number of firms will be reduced to perhaps as few as 10,000 from 150,000. And each HMO is likely to serve at least 20,000 people. This doesn't mean that the solo practice of medicine is going to disappear. In fact, our hope is that the HMOs will provide genuine competition for the existing way of delivering medical care and that both systems will benefit by this competition. I think it would be very unwise if consumers got locked into having to go to an HMO and couldn't say to the HMO, "Nuts to you, you're giving me bad medical care," or "I want out and I want to go back to my family doctor and I'll take my chances on a fragmented health care system."

HMOs can be organized on either a profit or a nonprofit basis or some sort of combination for profit and nonprofit groups as is the case of the Columbia Maryland Plan. The Columbia Maryland Plan is a partnership between an insurance company, in this instance Connecticut General, and Johns Hopkins University. they have gone together to deliver medical care in a new town. I think that the most likely sponsors, at least on the basis of those who have come forward so far to try to organize HMOs, are likely to be multispecialty group practices. They seem to have the jump on everyone in that they already have at least organized physicians, although it's no pushover for them to enter this field because so many multispecialty group practices emphasize the very highly specialized aspects of care and don't provide much in the way of primary care. Hospitals too will organize HMOs, although few have done so thus far. We can expect medical societies to create a loose form of HMO. We can expect groups of consumers to organize them, medical schools will, insurance companies will, and industrial corporations will.

An HMO will combine the capacity to provide medical care with an insurance and marketing capability. It will have a carefully planned mix of physicians and other health personnel. In fact, our best data on what the optimum distribution of specialists serving large populations is, is the data that we have from the existing prepaid group practice variant of HMOs. We can expect HMOs to own hospitals or have some sort of arrangement with hospitals. Whatever combination of resources they have will be based on the health care needs of the people they have enrolled and the set of benefits that the HMO is proposing to provide. They must use hospital beds and professional resources in a cost effective manner. I think this is evidenced by the current use of health manpower and hospital beds in the existing HMOs. They require about two hospital beds per 1,000 individuals that they serve. They require about one physician per 1,000 enrollees, although some of them drop to 3/4 physician per 1,000 enrollees and do some substituting of other kinds of health professionals for physicians.

I think we're going to see two main HMO organizational variants and a lot of things in between. The first is what we've come to know as prepaid group practice, based on a tightly organized medical care system, a group of salaried physicians who have some direct working relationship with a hospital. The other type I think we can expect are medical society

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foundations based on a working arrangement between doctors, where doctors will continue to work out of their own offices on a fee-for-service basis and where the integration will be an economic integration and perhaps integration of information systems, but not a physical integration. These are most commonly referred to as risk-sharing medical society foundations and perhaps the best prototype of this is the Clackamas County Medical Society Program-you can see a description of that in Hospitals, March 16, 1971 issue.

If HMOs do become the dominant provider of health care, there is going to be a substantial reduction in hospital beds in this country because right now we have 4.1 hospital beds per 1,000 in the United States and, as I said before, HMOs us 2. Similarly, I think we're likely to see a shift in the fields of medicine that doctors specialize in, a shift in the character of each of our jobs. There is going to be much greater emphasis on primary care. The current HMOs, at least the more highly organized ones, use from 60-70 percent of their physicians in primary care, whereas at the present time, in spite of all the talk about the shortage of primary care physicians, only 30 percent of the physicians in training are in training to become primary care specialists. I'm not talking just about the GP or family practice training programs, but I mean in training to be an internist, pediatrician, obstetrician, or family practice specialist-30 percent! In reality, if the current trends continue as to what fields doctors enter, we could double the output of the nation's medical schools and still not meet the needs of people for primary medical care. In my opinion, maldistribution of physicaans is a much more serious problem than the supply of physicians. In fact, I don't think there is a shortage of physicians. There are 1.3 physicians, in practice per 1,000 [population] in the country right now. If the existing HMOs are any example, one physician per 1,000 is probably more than adequate. For nurses and other allied health professionals, you can anticipate that your work setting is much more likely to be an ambulatory care setting than a hospital setting. The range of in-patient settings will be much greater than it is right now. Much greater reliance will be placed on motel-like facilities and less elaborate in-patient facilities. On the other hand, the average hospitalized patient is likely to be more seriously ill than the hospitalized patient today.

The next essential characteristic of this HMO idea is the notion of serving defined populations. The HMO serves a group of people who voluntarily enroll exclusively with it for their health care. And I emphasize voluntarily. Consumers will agree to obtain most of their health care from the HMO for a period of at least a year (most contracts of this type are for a year, although it might be desirable to have much longer contracts which would permit lower rates). If contracts were for a longer period, the incentive for the HMO to become more interested in the effects of environment and preventive services on health would be greater. If you had to keep somebody healthy for five or ten years, I suspect that the object of the game would change even more than it does when you're responsible for them for a year. But certainly being responsible for them for a year is a lot different than being responsible for them for one office visit and having the responsibility end there.

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In return for the agreement on the part of the consumer to get all of his care from this organization, the organization has to guarantee to make that care available. At the present time, having plenty of money to buy medical care doesn't necessarily mean that you're going to be able to find a pediatrician or an internist when you most need him. At the same time, the HMO incurs the obligation of making the care available. It also incurs the obligation of being responsible for the quality of the medical care that it provides. Both the consumer and the provider should benefit-the consumer knows that care will be conveniently available, and the HMO has a group of people that it knows it's responsible for and can array its resources in an ideal way to serve them.

The third basic element of the HMO concept is capitation and prepayment. The HMO markets its services through annual fixed-price contracts with consumer prepayments usually made by monthly installments. As you know, this method differs very sharply from the prevailing methods for reimbursing providers and is vitally important to understanding the HMO approach. In fact, I think it's the most important element. I think that once one goes to prepayment and goes to a situation where the organization has to guarantee to make services available, all of the other desirable organizational changes that take place follow from that. If I had to single out one most important change in the way that health care would be delivered, it would be the change in the way it's paid for because the contract has the effect of aligning the interest of both the organization and the enrollees in maintaining health.

The salutary effect of this change in incentives is quite apparent in examining the performance of the existing HMOs. The existing HMOs are serving approximately 8 million persons, yet one of the criticisms that has been made of the HMO notion is that it hasn't really been tried. I don't think that it's exactly fair to call a system of services that provides medical care to 8 million people, and has been doing so for up to 25 years, an experiment. The HMOs that already exist in the United States serve as many people as the Swedish Health System. The Kaiser organization alone is probably the largest single medical care organization in the world. It's hardly an experiment. But, to most economists, it is still the marginal form of care in that only 8 million people in the United States are being served by it rather than 100 million or 150 million. We can't be at all certain the people that are working in these existing HMOs are typical doctors and nurses and that these are typical hospitals. They may be very atypical. So we must be somewhat critical of any data that seeks to generalize on how an HMO-based health system in the future might function. However, there are certain things that seem to be reasonably clear.

First of all, hospitalization is significantly reduced in HMOs. This is accomplished by performing some procedures, such as minor surgery, on an ambulatory basis and by eliminating many unnecessary procedures. The analysis of reasons for hospitalization shows that HMOs hospitalize less frequently for things like common respiratory infections and minor surgical conditions, such as benign neoplasms, tonsillectomies, and accidental injuries. The reductions are quite

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selective and they appear to reflect vigorous professional control. HMOs hospitalize just as frequently for severe problems, like myocardial infarction. Incidentally, HMOs, at least the existing ones, don't seem to particularly shorten hospitalization. In fact, patients who are hospitalized on the average are more seriously ill and may actually raise the unit cost for each hospital day.

It should be pointed out that the selection of cases for hospitalization is more consistent with good medical practice in HMOs than it is in conventional delivery systems that attempt to reduce utilization by merely restricting the number of hospital beds. One of the things you're going to be hearing over the next few months, as the debate goes on as to how to reduce medical inflation, will be that the best way to do it would be to just reduce the number of beds to, say, 2 beds per 1,000. After all, we have 4 beds per 1,000 and the wrong people are in the hospital. Why not just drop the number of beds to two if that's where the high costs are? There have been some studies of what happens when you drop the number of hospital beds without doing anything about the organization of health care. The consequences might be termed the emergence of the politics of hospital beds-certain individuals will manage to capture the beds and others will not and who captures the beds won't necessarily have anything to do with patient needs. In fact, in a study that Martin Feldstein did of the incidence of hospitalization for tonsillectomies in England, he found that the incidence of hospitalization for tonsillectomy (which, in my opinion as a pediatrician, is largely an unnecessary operation) didn't drop when the number of hospital beds was reduced. In spite of a shortage of hospital beds, the tonsillectomy rate persisted at the same level. The tonsillectomy rate in England is a lot more exemplary than it is here. Nevertheless, it isn't as low as it is in HMOs in the United States. There is a very very important phenomena for us to understand because as I say, I think one of the cost-saving proposals that is likely to be made is just simply to reduce the number of hospital beds without doing anything to influence the social system that determines how the beds are used.

Do HMOs really reduce cost? It appears that they do. They reduce health care costs for both families and individuals, and they seem to cover a greater percentage of total costs than most insurance plans. The amount of cost reduction in most studies ranges from about 5 to 25 percent, with the most spectacular cost reductions being in Group Health of Puget Sound. In Medicare alone, the cost reductions of the Group Health of Puget Sound are in a range of 30 percent for a matched Medicare group of nonsubscribers from the same community. These cost reductions have been accomplished with remarkable traditional forms of medical practice. I think that the existing HMOs have had to make many concessions to the way medical care was delivered at the time they were installed. Otherwise, they'd be accused of skimping and scalping the public and not practicing good medicine. Therefore, the main savings that existing prepaid group practices have managed to achieve has been through reduced hospitalization and not through such things as more effective allied health personnel or preventive health services.

These HMOs and two new HMOs can be expected to improve their

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record of innovation. In so doing, emphasis must be placed on more effective use of health manpower. Our contention is that much of the inefficiency in the current health system is due to rather rigid adherence to the professional model for organizing what we all do. There has been a rather arbitrary division of labor in our field. In each step, each new profession has emulated the medical model of the doctor having this license to practice medicine and with no one else being permitted to do it. Each one of the other professions has pretty much followed this pattern with each medical specialty and each allied health profession protecting their turf ethically and legally so that no one else is permitted to do what they do. On the one hand, this protects each profession from encroachment by others; but on the other hand, it puts a ceiling on what each of us can do and prevents us from moving upward in our responsibility. Also, the professional model calls for control of the content of training and the conduct of training by the profession. Those who control the content of training and places where training takes place are, in my opinion, being increasingly removed from typical actual practice. I think that's the explanation in a large measure for the skewing of the specialty distribution. How can we go on producing more cardiac and neuro surgeons when we don't have enough pediatricians or personal physicians?

The other critical element of the professioanal model is being paid on a piecework basis, on the basis of the task that each profession performs. Each profession performs a certain group of tasks, each task has a price on it and a financial transaction takes place each time we do our little thing. HMOs represent an opportunity to change all this. Some of you might not think of it exactly as an opportunity, but we will make the argument for it anyway. By being paid for health, rather than being paid for office visits, physical therapy treatments, special nursing services, or hospital days, the HMO is in a much better position to alter who it is that actually performs the service because the expectations of the patient are different. The patient has not paid to see a pediatrician, he has paid for pediatric health care so that it ought to be possible for the HMO to use the person most ideally suited to perform a given job, not just the person who is ideally licensed or eligible to be paid to do the job. People should be allowed to provide health care on the basis of their ability to perform and their experience rather than on the basis of an arbitrarily defined set of legal constraints or a set of tickets that you bring to the health care organization when you arrive out of school. We hope to see some of the legal barriers to upward professional mobility removed. At least one of the pieces of HMO legislation has in it an option for the HMO to permit anyone in the organization to perform any task providing that the HMO is willing to be responsible for the result. I hope that the larger organizations will be in a better position to provide on-the-job training and that this training will be related to the needs of the consumers that they are serving.

What about the quality of the care provided in existing HMOs? The ultimate test of any health care system is the health of those it serves. We indicated there was less hospitalization, less surgery, and lower costs, but that's not necessarily synonymous with desirable care

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since costs and services may be low for very undesirable reasons. The results of three common indicators of health-premature birth rates, infant mortality, and elderly mortality-suggest that at least the HMOs that have been studied can improve chances for life itself. And I might say that studies of delivery of health services in these organizations and their results are relatively small. Nevertheless, they represent some of the best studies of the quality of medical care available in the United States. In providing all medical care to a large group of individuals it is possible to learn whether or not medical care makes any difference. One of the toughest questions that our policy research group was asked in the course of conferring on health policy was, "We spend 7 percent of our gross national product right now on health; that's among the highest in the world, there's one country higher-Canada; if we spend more, will Americans be healthier?" Quite honestly we don't have the answer to that rather fundamental question because, given the present health system, we can't get the answer.

Let me close by trying to point out how the health maintenance strategy differs from other national health plans. The differences include: first, the notion of competition and choice; second, the type of quality controls that are proposed to be applied with HMOs; third, flexible organizational structure, and finally, some difference in the approach to achieving health system reorganization.

The health maintenance strategy seeks to stimulate competition among providers of diverse organizational styles and modes of patient care. The intent is to reorient the health industry so that the economic and social forces governing its behavior would be more compatible with the public interest, and every American would have an opportunity to make an informed choice between traditional forms of care and HMOs and between competing HMOs. This approach runs counter to two things:

First, the present situation where it's improper to advertise, if you will, to attempt to differentiate publicly one source of care from another-can you imagine a mobile guide to hospitals that told you whether or not the mortality rate in cardiac surgery was 80 percent in one hospital as compared to 10 percent in another? It seems to me that as a consumer one has a right to know that sort of thing. After all we expect consumers to make the choice.

Competition also runs counter to the notion that is common to much of health planning-that we should allocate geographic territories to health care organizations on some sort of monopolistic or only partially competitive basis. Some health planners believe that to rationalize the distribution of health services it will be necessary to assign hospitals and doctors to territories. Patients would then be required to obtain care within their own territory. This, in turn, means reducing or eliminating competition. Many are wary of a market approach to health care delivery. They contend that such an approach has already been tried and has failed, and that the present health care

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system is an example of a free market operating unfaltered. Our contention is that the market has not really been tried and that a market can't operate with uninformed consumers. If the consumer makes his choice at random, those that are providing poor care are just as apt to get customers as those that are providing excellent care.

The notion that one can have uninformed consumers and have an effective health care market, particularly when patients must make their choice at a time when they are ill and in need of help immediately, is absurd. Therefore, to make a market work in health care, we have to agree that consumers are going to be given information to help them make better choices. We'll also have to agree that disparities in income or social status are not going to give people an unequal command of health resources that are perhaps in short supply or at least just barely adequate in supply. Finally, we can't permit inequitable health levels between consumers to discriminate against high-risk population in HMOs or to discriminate in favor of high-risk population in fee-for-service. The present system discriminates in favor of those who need the technically interesting, very sophisticated kind of medical care. So we got a skewing of effort in the direction of the more elaborate aspects of medical care. On the other hand, the HMO system might discriminate in just the opposite direction. Any design for a health system has got to assure reasonably open enrollment. The proposals for HMOs involve providing consumers with comparative information about systems of care and making certain that the HMOs have open enrollment so that anyone who may want to enroll with them can, without some sort of artificial barriers put in their way.

Finally, let us turn to the question of quality. An important advantage in the HMO idea is that providing health care to an enrolled population facilitates the evaluation of performance on the basis of outcomes rather than inputs. Most of the present systems for measuring the quality of medical care, or the ability of an organization to provide good medical care, are based on who works there and what their physical facilities are like (perhaps getting into some processes like frequency of staff meetings, quality of records, or specified lab work prior to surgery). In general, the control of quality is based on what happens or who works in the hospital or health care system rather than what happens to the patients that are taken care of by it. It seems much more logical to base the judgment on the quality of health care systems, on outcomes, or the results of medical care. What are the death rates and disability rates among the population served? Do the people that are served by the HMO indeed have less absenteeism from work or school? Are the desired clinical outcomes achieved in a given group of patients? In order to shift this method for judging performance, I suspect that we have to create a whole new machinery for measuring quality, and that we will have to create an independent federal agency that would regulate HMOs. Presumably the time is right to create such a regulatory agency rather comparable to the Federal Aviation Administration. I don't mean an agency in HEW, but an independent public regulatory agency that might regulate and license nursing homes, HMOs, and other organized systems of medical care. This agency ought to be given a large R & D budget so that it can develop these improved systems for judging quality and establish its own reputation for excellence.

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As to the methods for effecting change in the health delivery system, let me say this. The Administration is resorting to two techniques: one, persuasion by having the President and the Secretary of HEW define and advocate HMOs. As a matter of fact, I think it has been the most effective thing they have done to date. They have legitimized change. The Administration has not succeeded in getting new laws passed or putting up new money to change the health care delivery system. The willingness to buy health service from HMOs through Social Security, through a new national health insurance scheme, or what have you, represents the second method for effecting change. Money in the form of loans and grants will be needed for new HMOs. I'm quite discouraged about the progress that has been made by the federal government in committing their purchasing power to HMOs.

The HMO idea was first proposed to Congress in March 1970. The necessary change in Medicare has passed the House of Representatives twice, it's passed the Senate once, and still we don't have new federal legislation effecting the development of HMOs. The same old legal barriers that existed in most states to this kind of health organization are still there, and the willingness on the part of the federal government to either purchase care from such organizations or to provide large sums of money to get them started isn't there yet. Our willingness to try new and perhaps better ways to deliver health care is being tested. So far the American health industry has been remarkably responsive to the HMO idea. There's an HMO in your future!

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A CONSUMER'S VIEW OF THE HMO

Samuel Pollock
President
Meat Cutters District Union 427, Cleveland

I am always delighted to return to the campus of the University of Wisconsin since my first visit in 1945 as a student at the University of Wisconsin School for Workers. It is of some interest to note that I was on the campus only a few weeks ago to discuss labors' responsibility for promoting and participating in the development of Group Practice Prepayment Plans as part of their collective bargaining. The group I spoke to was the United Steel Worker Union officers and members attending their fourth year of a labor education course. The fourth-year student curricula dealt with the crisis in health care and labors' role and responsibility for health care services and alternate health care delivery systems.

I also can't help taking advantage of my return visit today to relate a little of the history of the issue of government health insurance, which is or should be a matter of pride for this great university.

Following the enactment of the British National Health Insurance Act in 1911 (not the present law) a movement began in this country to enact social insurance, starting with health insurance, on a state-by-state basis. This movement was spearheaded by a group of University of Wisconsin economists (led, if memory serves me right, by John R. Commons) known as "The American Association for Labor Legislation," founded in 1906. So you see doing something about the health care "crisis" got started early in Wisconsin.

I've got a confession to make. Just at the time when I had some major negotiations out of the way and I thought I would be able to "eke" out some time to jot down some fresh notes for my discussion here, President Nixon "unstabilized" my work life and time schedule when he issued the executive order August 14 to stabilize the economy. So I address you today hoping that my comments, much of them purloined from previous addresses, will be new to you because you are a new audience.

Today the number one legislative goal of organized labor is National Health Insurance, with great emphasis on Group Practice Prepayment. The reason for that security should be obvious to anyone who has seen the hard-won gains of union workers gobbled up by steadily increasing costs of health insurance. To us it's a great problem. To millions of others, not covered by union contract, the problem has reached tragic, even disastrous dimensions.

American medicine is indeed the most advanced in the world, but its cost is thrown out of all perspective by an 18th-century delivery system. Care is provided in the most expensive ways-single doctors, inefficient hospitals, isolated units, uncoordinated and often duplicative.

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To get at the problem of cost, we must get to, and reform, the problems of the health care delivery system.

A national financing system, structured similarly to Social Security, would create the necessary financial leverage to encourage change to a more rational delivery system and economically discourage inefficient, overly costly care. Presently there is no financial leverage on costs.

More than 1,000 insurance companies with more than 1,000 forms, 1,000 different variations of policy fine print, and 1,000 payment methods keep compounding the chaos. If a National Health Insurance program did nothing more than create one financing system, one system of benefits for all Americans, one source for payment to providers of health care, its value would be immeasurable. But it would solve only part of the enormous problem. It is with an eye on the larger problem that labor has chosen to support, promote, develop and participate in Group Practice Prepayment Programs.

Prepaid group practice is no longer new. It no longer needs to prove its worth. Where it is practiced, it has proven to be more efficient and less costly. Doctors in prepaid group practice have delivered-yes, delivered-medicine of very high quality. It operates on the simple basis that it costs less to prevent illness than to treat illness. Emphasis is on preventive medicine, early diagnosis and proper use of specialists. As a result, hospitalization rates are 25 to 50 percent less than for persons covered by commerical insurance; surgery rates are halved.

The doctor's time is more efficiently used-treating nearly twice as many patients. This is because doctors spend less time on business matters and more with their patients. Overhead costs are curtailed because many doctors share facilities and equipment, as well as the expense of medical assistants and office personnel.

The patient makes one payment for virtually all his medical services. And the cost is 25 to 33 percent less than private insurance. Specialists and laboratory facilities are available in the same building, reducing the time spent in transit from one doctor's office to another. Since the care is paid for in advance, the patient is encouraged to seek early care and treatment. No doubt about it, prepaid group practice works.

All of us are consumers of health care. But unlike consumers in the market place, we have no opportunity to do any competitive shopping for health care.

Organized labor has a major responsibility, whether they wish it or not, for making available the services for which dollars were negotiated. It is a natural commitment of collective bargaining to search out areas for getting the worker the best consumer value for the wages negotiated by the union.

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Labor long has had a concern with assuring that the working people get good health care both on the job and off the job. This concern was matched either by political action or through union collective bargaining. The efforts and results of labors' concern pursued an uneven but progressive course. Health care for the more advanced and developed societies became a national policy responsibility, except for the United States.

In the U.S. for a variety of reasons, the unions were compelled to seek health care for their people primarily through collective bargaining and then press for it in the political arena. Progress of the unions for health care spurted during World War II when, due to wartime control over wage increases, so-called fringe benefits including health and welfare were expanded through collective bargaining. It was in the late 40's when the first national effort was made by unions and socially oriented and concerned groups, such as co-ops, consumer organizations, etc., in the U.S. for National Health Insurance known as the Wagner, Murray, Dingell bill. Resistance principally from the organized health providers and other conservative elements defeated this earlier effort. The unions then intensified their bargaining for health care-primarily financing of a limited level of benefits.

It was this collective bargaining which made possible the tremendous growth of Blue Cross and to a lesser extent Blue Shield plans as mechanisms for prepaying hospital and surgical fees. One must keep in mind that the unions negotiated the monies to pay for such services. But neither the union nor the insurance carriers took responsibility for delivery. I sometimes describe this system as one in which we provided the member with a "hunting license" to find his own health service as needed. The health and welfare fund or employer then paid for such covered benefits, which, based on a fee schedule, did not necessarily cover the entire cost or billing.

Year after year following World War II, collective bargaining ground out ever-increasing monies for improved benefits and to meet voraciously increasing costs. There were times, presently on the increase, when the unions, national and local, depending on the geography the contract covered, were spinning their wheels in bargaining, grinding out monies to keep benefits going with little hope of improving the level of medical, surgical, hospital benefits. There were times when some unions, with inadequately financed benefits, in order to meet increased hospital and surgical costs in the middle of a contract term, had to accept reduced benefits or go to their members for membership contributions to keep the benefits going. This process intensified after 1955 and started to gallop in the middle 1960's, and under the impact of Medicare and Medicade and fortified by the general inflation, costs got jet propelled.

During the experiences described here, primarily the mid-1950 to mid-1960 period, a technological revolution was taking place in all phasis of production and service. Its impact on the consumer of health care, among other responses, was to transform the consumer from a

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passive to an articulate "demander" of all kinds of services, with medical care as one of the major concerns. As the consuming public became more sophisticated and the "mystery" surrounding the practice of medicine continued to be dispelled by mass media of all kinds, greater interest was directed toward the quality of care.

Today the point has been reached and passed where most people feel that access to medical care of high quality is a right to which every American is entitled. The more effective medical care became, the more working people demanded it be made available to all. One needs only to consider the fact that the amount of money being spent for this care is in the neighborhood of 7 percent of the GNP or $70 billion (1970) and still rising, to realize that the public would start questioning the entire medical care system.

The labor-consumers, as the largest body of organized consumers, were made aware of the fact that private health insurance paid out in 1970 more than $15 billion, three times the amount paid out twelve years earlier, most of which was generated by collective bargaining. You do not have far to search for the basis for labor altering the collective bargaining goals on health care. Labor's deliberately altered role is to change from buying insurance to that of directly arranging the service itself through a prepayment group practice plan offered through dual choice provision in the negotiated labor agreement.

People are somewhat puzzled by the determined role of organized labor in seeking to develop direct service health care programs in cooperation with the frustrated public. Health providers see it as a sort of power play by union officers. Nothing could be farther from the facts. A quick digression by way of look at the actual mechanism should, I hope, serve to illuminate labor's concern and program.

The major pressure on the unions comes from its membership, the largest body of organized consumers of health care benefits. What good is it to negotiate the many dollars for health care benefits if the services are not accessible or available, lack minimal quality or take a big bite out of the members pocket (the monies for this are considered part of wage costs)? Yet, despite the relatively high levels of cost reimbursement to the user of the physician or hospital services, this still leaves the member frustrated for adequate care when he or his family needs it. Too often the rank-and-file demand, for lack of understanding, is for more funds for services that can not be made available in any adequate, reasonable or qualitative measure.

The union officers' inclination was not to get involved and to limit their responsibility to just negotiating "sick" insurance for the member. But the unions are no longer able to avoid the need to assure the delivery of the service and to do something with the out-of-pocket expense.

Most consumers, and this included union members and officers alike, had almost unquestioning faith in the solo practice, fee for service arrangement for sick care. Certainly health care was a misnomer in the

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absence of preventive and maintenance health care systems. But as the health care crisis continued and deepened, their faith diminished and their demand for some other system of health care sharpened. In the pass decade a few union officers had been calling attention to the unions' responsibility for health care as contrasted with the conventional "sick" care.

I believe it to be of some interest that the judgment was reached by some of us in labor, that it would require an economic thrust of major proportions, private or government, if prepay group practice were to be developed to meaningful national proportions. In this period of time, the political relationship of forces being what it is, some of the unions determined that collective bargaining was the most viable force to get this done. Pioneers in this concept, such as the Amalgamated Clothing Workers, the Ladies Garment Workers and Teamsters Local 688, led the way. Special emphasis on the national level for this direction through collective bargaining commenced about 1963 at the National AFL-CIO conclaves. By 1967 direct reference is made to the union responsibility to initiate development of group practice prepay health care services and restated as late as February 1970 and ever reiterated in recent weeks.

New directions were needed to assure getting the quantity and quality of health care to be realized from negotiated health and welfare benefits. It usually first took the form of joining with others in the community for hospital reforms, finances and resources, to beef up medical care into more adequate arrangements, but still largely in the nonsystematic solo practice, fee for service arrangements. Prepaid hospitalization and surgical fees, described by us as "horizontal" care, had been the principal direction since the 1940's. As labor or, for that matter, most consumers became better informed, proponents came forward for group practice prepay direct-service plans to provide preventive and early detection care as well as acute and hospital care.

Today, organized labor's emphasis for health care for its members and the community is generally on group practice prepay arrangements. It seeks this as a major alternative to solo practice, fee for service. It does not seek this as a sole substitute or as a panacea. The initial resistance of virtually all commercial insurance carriers and the Blues, as well as organized medicine and on a lesser basis employers, to prepay group practice, compelled the unions to negotiate into the union agreements dual choice provisions to take advantage of prepay group practice where such existed, such as Kaiser on the West Coast, HIP in New York, and so on.

Today, the union movement, as the organized consumer with "clout," is moving through collective bargaining, then joining in the community with like-minded consumers, to develop the program with the health care providers for comprehensive health care through a prepay group practice health care delivery system. To the extent that the federal government encourages the HMO concept, particularly Group Practice Prepay, the unions perform an allied service.

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Somewhat ahead of its time but not any too soon, we have witnessed this process in Sault Ste. Marie by the steel workers' union and in St. Catherines by the auto workers' union. The unions in Cleveland made a significant contribution with the development of the Community Health Foundation, that in 1969 merged into the Kaiser Health Foundation.

In the U.S. there will be at least twenty such programs under way in as many different cities which are at various stages of development. But new dimensions are also developing with reference to the serious interest shown by the Blues (Blue Cross and Blue Shield) and commercial carriers in working with or developing group practice prepay direct service in a number of cities in the United States.

It is no longer whether we will have a significant development of prepay group practice, but how soon and how many.

The when and how of group practice is in a race against time. It is against the time when National or Universal Health Insurance to finance the full spectrum of health care will be upon us in the states as it is now a fact of life in Canada. Not to have effective rational, comprehensive group practice health care delivery systems available and accessible in time to meet the universal health care coverage, or made an integral part of the yet-to-be-enacted National Health Insurance for planned development, could be short of a calamity. Available dollars unfortunately do not of themsleves assure available and accessible care. Like Parkinsons' law that "work expands into hours available," the medical and hospital fees will expand into the dollars available-but this does not necessarily make for adequate and quality services.

This concern is shared by those in the top echelons of labor and many knowledgeable union officers and members in the front lines of collective bargaining and political action. Labor's support for National or Universal Health Insurance is well stated in the AFL-CIO Executive Council policy report on National Health Insurance, February 17, 1970. Time limitations permit only quoting portions of the statement. "The magnificent new discoveries of talented research workers, the advanced state of the medical sciences and the rapid development of the application of computer technology to medicine now make the achievement of this long-sought goal a realistic possibility. However, the organizational arrangements by which medical care is delivered to the American people are inadequate to the task. What we have today is a sophisticated 20th-century medical technology shackled to an 18th-century delivery system. This is the major cause of the crisis we now face in health care.

"Benefits should be comprehensive, including preventive, outpatient, inpatient and rehabilitative care in every appropriate setting. These inclusive benefits would permit the physician to select the exact type of treatment appropriate for the patient's need regardless of cost factors.

"The National Health Insurance program should contract for all

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medical services on a prepayment basis. Eligible contractors would include medical and dental societies, hospitals, groups of primary physicians and multispecialty groups. All would be paid on a per capita basis but how each contractor distributed the funds it received to individual doctors would be strictly an internal matter.

"Every man, woman, and child in the nation-rich or poor, working or unemployed, old or young-should be eligible for the complete range of services."

The experience of our District Union 427 members and their families verifies the experience for the some 8 million persons now served by prepay group practice and demonstrates the following:

Prepaid Group Practice Direct Service assumes the responsibility for comprehensive medical care for a defined population.

It assures the user that at any time, day or night when ill, someone is available to provide service. Our direct experience is that it is appropriate and of high quality.

The doctor is able to use the best available medical knowledge, not being deterred by an outmoded fee schedule.

The consumer and the professional through the organized setting have the best opportunity for resolving "sticky" and difficult issues.

I had occasion in 1969 to address a meeting of nurses and other concerned citizens arranged by the Commission on Nursing and Nursing Education. I concluded my comments then and now with what I hope is appropriate in this setting.

How does all of the foregoing relate to this conference? If there is one area of nursing education on which I may make an observation it is the almost total absence from the current education programs, which now are under scrutiny, of alternate settings or arrangements for providing medical services sought by the consumer. It calls for change by the medical professions, including the nursing profession.

I ask those present, particularly the registered or baccalaureate degree nurse, How do you make your training, once it is determined what that training should consist of, available to the users of the services?

What are the more effective, rational and comprehensive care arrangements in the medical care delivery systems in this period of scientific and technological capabilities but with great shortages, primarily because of maldistribution? Is this not a major concern of the nursing professions?

I am on the side that says, without in any way denigrating what is, "We need to study, to understand and to provide the services we trained to provide in those alternate arrangements which meet the public need for a comprehensive health care system or systems."

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APPLICATIONS AND EXPERIENCES WITH HMOs

Group Health Cooperative

Robert B. Pelzel, M.D.
Assistant Director (Medical)
Group Health Cooperative of Puget Sound, Seattle

I would like to tell you about the organization for which I work, because it is one prototype of an HMO.

Formed in 1947 with the aim of providing the Seattle area family with better medical care at lower cost, GHC is a nonprofit, consumer-owned cooperative offering prepaid comprehensive medical and hospital care through its own staff and facilities.

It has grown from an initial group of 200 member families (approximately 600 people) to a present enrollment of approximately 145,000. Its enrollees comprise about 10 percent of the Seattle area population. These enrollees represent a wide variety of ethnic, political, religious, educational, and occupational backgrounds. The distribution of GHC members by age and sex is virtually a mirror image of the population of King County.

We are registered with the State Insurance Commissioner as a "Health Care Service Contractor." We are not an insurance company. As our name implies, GHC of Puget Sound is owned and operated by the people who use its medical and hospital services. We are the largest health care cooperative in America.

Group Health owns and operates its own 302-bed hospital. It also operates outpatient medical centers in downtown Seattle, Northgate, Burien, Renton, and Capitol Hill. A sixth medical center will open in Lynnwood, Snohomish County late this year. A 150-bed satellite hospital will later be built in connection with the Lynnwood medical center. Work is progressing on a South-Sound medical center in Olympia, capital of Washington about 60 miles from Seattle. It is programmed to open in July, 1972. Another medical center and satellite hospital is being planned east of Lake Washington in the Bellevue area.

The "co-op member" and his family comprise about 50 percent of Group Health's enrollees. He pays an initial capital investment of $175.00 which goes toward purchase of new equipment and facilities expansion, thereby giving him a share in ownership of the organization. Thereafter he pays monthly dues which for a co-op family of four (two adults, two children) are approximately $44.00 per month for comprehensive health care coverage, including drugs. Dues represent the subscriber's per capita share of the cooperative's total cost of operation.

The other 50 percent of Group Health's enrollees are members of industrial and employee groups served under group contracts negotiated

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with their employers, with capital dues incorporated in the monthly premium. Largest of these is a group of approximately 13,000 federal employees and their dependents. A small percentage of the enrollees are those originally covered under group contracts not eligible for co-op membership, but able to continue coverage through a group conversion plan. All income of the cooperative is devoted to providing medical care and facilities for its members and subscribers.

The cooperative, including outpatient medical centers and hospital, is operated under the direction of an 11-member policy-making board, elected by the co-op membership for staggered three-year terms.

The board appoints only two persons. The director, who is directly responsible to the board, oversees the operation of the total organization, which includes more than 1,000 employees. The board also appoints the hospital superintendent who reports to the director.

The medical staff, a group of 140 full-time physicians, contracts with the board to provide medical care. A "per capita" system is used in paying the medical staff. The staff receives a carefully budgeted amount of money for each person covered by GHC. Thus, if there is an unexpected growth in membership, the staff is compensated for the extra hours of work required. Medical practice is the responsibility of the physicians. The staff is self-governing and democratic, and its contract forbids lay interference in medical decisions. Staff business is conducted through the Chief of Staff and an elected Executive Committee of the Medical Staff. Many doctors hold appointments at other hospitals in Seattle, as well as teaching positions at the University of Washington School of Medicine, Children's Orthopedic Hospital, and other teaching institutions. Freed of the administrative and financial aspects of medicine, the physician can devote his efforts to those interests that are important to his professional life.

I would now like to come down on one aspect of Group Health's structure which is both its most unique characteristic and its greatest strength, namely, consumer participation in the operation of the plan.

Group Health is divided into eight geographical district organizations. Each of these districts has its own officers and executive committee, and each holds a quarterly meeting. Half of each meeting is devoted to health education programs, and the other half is devoted to a discussion of Group Health problems. Each district elects a member of the Board of Trustees.

One of the dynamic strengths of the Cooperative is derived from the work of specialized Board Committees appointed as task teams by the Board of Trustees.

Members of these Committees meet at regular, frequent intervals to monitor and assess Group Health's performance in the business of delivering quality health care at the lowest possible cost to members and enrollees and, as well, to recommend actions for Board consideration.

Couples with these basic roles of auditing and advising, Board Committee sessions provide a constant series of interfaces for free

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exchange of information, opinion, and judgments. From this process emerge data and guidelines which help shape decision and policies adopted by GHC Board.

GHC Board Committees are all embracing in structure and composition. Each Committee Chairman is a Board Member and every Board Member heads one or more Committees. Thus the Board not only gives leadership but is perpetually aware of and responsive to Committee views and activities.

Most committee members are appointed from the ranks of the Cooperative's membership with an eye to available professional and occupational skills and capabilities. Membership of most Board Committees includes one or more physicians from the Medical Staff who contribute knowledge and points of view of professional health service providers.

These physicians, in turn, learn firsthand of the concerns, needs, aspirations and plans of the Cooperatives consumer-owners. In addition, all Board Committee meetings are attended by appropriate Administrative Staff members who act as resource personnel for the Committee and, in so serving, learn directly about consumer interests and needs. GHC Board Committee meetings constitute a continuous, multifaceted forum for communication and teamwork among representatives of the various groups vitally concerned with the continued success of the Cooperative.

Let me mention each of the eight principal Committees briefly. There is a Joint Conference Committee in which representatives of the medical staff and board consult together to work out the staff contract, develop annual staff budgets and consider other matters of mutual concern such as physician-patient ratios. This committee reviews the qualifications of candidates for the Medical Staff, and transmits their evaluations to the Board for approval.

Member Services and Hospital Committee conducts monthly reviews of Hospital Utilization Reports and other service statistics; considers new services to be offered, and projects the physical and staffing requirements involved. New service areas are also scrutinized with the view of arriving at requirements and timetables. Proposed changes in member service contracts are reviewed by this committee with the aim of increasing benefits whenever feasible.

Fiscal and Management Committee assists management in the analysis of the financial status of the Cooperative to keep the Board of Trustees aware of trends. Recommendations are made to the Board on dues, budgets, and financing in order that the Cooperative can operate on a sound fiscal basis. The Committee also reviews nonmedical departmental performances and provides advice on improving operational efficiency.

The Community Affairs Committee advises as to health care legislation in the Congress, State Legislature, and local government. It develops programs in cooperation with community service agencies. In addition, this group maintains liaison with government agencies on behalf of the Cooperative.

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Many active participants in the Cooperative contribute through the District Activities Committee. A major concern of this committee is how to involve more and younger members in our district executive committees and quarterly district meetings. Other Committee functions include our health education program, improved communication at all levels, leadership development and consumer satisfaction.

The Facilities Committee reviews and advises as to all proposals for new GHC facilities; recommends appointment of architects as required; advises as to the status of construction projects, and gives guidance in the acquisition of property for present or future use.

The Mental Health Committee meets regularly with members of the Mental Health staff. This committee acts as the policy-recommending, advisory and consultative group in the area of Mental Health.

A Research Committee reviews all research projects conducted under the auspices of Group Health.

I have mentioned the functions of these committees in order to give you a picture of the degree of involvement of our consumers in the management of the organization. Mind you, it is the consumer himself, with the advice of members of the Medical Staff and Administration, who is making all these important decisions. This may seem to be a cumbersome method of operation, but it is also the secret of our success. Group Health thus possesses the same strengths and weakness as does a democracy. Winston Churchill was supposed to have said that a democracy was the most inefficient and ineffective form of government he could conceive of, except for all other forms of government in existence. If the average member of society is to have his say, then this cumbersomeness is the price which must be paid.

Now I would like to mention several of our newer programs which we think are quite in keeping with the concept of the HMO.

This month Group Health recorded its second full year of service to 1,000 families (4,500 people) who are recipients of Public Assistance payments. The program provides comprehensive health care to the recipients at dramatically less cost to the taxpayers--at least 25 percent less cost than under other systems.

The Cooperative has been awarded a grant by the Office of Economic Opportunity to create a health care plan for 500 low-income families in rural southeast King County. To help accommodate this group, a five-doctor addition was added to our Renton medical center.

The Cooperative has also been awarded a grant to provide care to 500 families in the Seattle Model City Area. Thus about 2,000 underprivileged families, comprised of over 8,000 individuals, receive their total medical care at Group Health.

Innovative programs of health care, such as the Medex program and the Nurse Practitioner programs, have been put into effect. Group

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Health was proud to train four of the first 14 graduates of the Medex program carried out under the auspices of the University of Washington, and we now have five more trainees from the second Medex class. This program puts the skills of former Armed Forces medical corpsmen to work as physician assistants. Nurse practitioners in the fields of pediatrics and general practice are demonstrating a high level of professionalism, freeing more time for physicians to treat the sicker patients.

We have our own three-year family practice residency program for young physicians, and in addition are helping to train in our facilities students from several colleges and universities in a number of medical fields including nurses, nurse anesthetists, clinic assistants, physical therapists, and social workers.

This year for the first time we are helping to train pediatric residents (and hope to expand) in other medical fields in the near future.

Despite a rather severe recession in the Seattle area for several years, Group Health has continued to grow at a rate of about 10 percent per year. We believe that this healthy growth is due to our providing quality medical care at reasonable cost. We believe further that much of our success lies in our corporate structure. Our patients not only receive their medical care at Group Health, but they own Group Health, and owning it, they see to it that they get the kind of medical care which they want and which they deserve.

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COMMUNITY HEALTH NURSING

Frances McGuire, R.N., M.P.H.
Director of Community Nursing
Mile Square Health Center, Chicago

The purpose of my talk is twofold: (1) to describe, analyze, and evaluate the role of the nurse in a comprehensive Neighborhood Health Center; and (2) briefly to discuss this role in relationship to a Health Maintenance Organization.

It may be helpful at the outset to offer some historical background about the Mile Square Health Center. The Mile Square Health Center is a comprehensive Neighborhood Health Center where I serve in the capacity of Director, Community Nursing.

In February of 1967, Mile Square Health Center opened its doors under the auspices of the Office of O.E.O. with Presbyterian-St. Luke's designated as the delegate agency and backup hospital. The name of the health center indicates the boundaries of the community it serves. This community is located in one of the 24 areas designated as poor by the Chicago Committee on Urban Opportunity. The area literally is one mile square and according to the 1970 census has a population of approximately 22,500 residents.

Almost a third of the population lives in public housing while the remainder live in generally old, dilapidated, and overcrowded private housing.

In 1970 the Mile Square community was approximately 98 percent nonwhite. Analysis of the population by sex and age distribution reveals 43.5 percent males and 56.3 percent females; 60 percent of the population is 21 years old or younger. Economically, this is a depressed low-income community. The average family income in 1970 was $4,400.

The unemployment rate is very high and probably reaches 35-50 percent among certain young male adults. Welfare assistance is received by slightly over 40 percent of families in public housing and around 25 percent of the nonpublic-housing residents.

Health criteria indicate an infant mortality rate of 47.3/1000 live births as compared to a city wide rate of 29.5/1000 live births in 1969.

The primary diagnosis made by physicians in 1970 was for Upper Respiratory Infections (18 percent). The second, third, and fourth most frequent diagnosis were for hypertensive diseases (10 percent), diabetes mellitus (6.4 percent) and obesity (4.6 percent).

A summary description of the Mile Square community indicates a high rate of unemployment, severe population density, poor and dilapidated housing, high infant mortality, and significantly high percentage of chronic diseases.

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It is against this background that I want to describe the role of nursing. The nursing department is committed to the philosophy of the team concept. Briefly, this means that the nursing department is divided into two sections, the clinic and the community health field team.

The majority of the Community Health Nurses are baccalaureate prepared, several of whom hold master's degree. A rotation system allows the nurse to work both in the clinic and in the field making home visits.

The majority of our Licensed Practical Nurses function as team leaders in the clinic, with some of them assisting the Community Health Nurse in the field.

Additional training allows the Licensed Practical Nurse to administer electrocardiograms, vision screening, and hearing screening, and give medication; thus freeing the Community Health Nurse to expand her role in areas such as child health assessment, exit interviews, and general health counseling.

A unique component of the health team is the Community Health Aide. Community Health Aides are recruited from the community and are assigned to the field teams in the ration of three Community Health Aides to one or two Community Health Nurses. The primary function of the Community Health Aide is to establish rapport and interpret the needs of the patient. The importance of this person stems from the fact that most white nurses (and some black nurses) have had little or no preparation to service a low-income community.

We need the Community Health Aide to make contact with the patient and explain the services offered by the health center. Additionally, the Community Health Aide counsels, and offers guidance to the professional member of the team in how best to interact with the patient and his family.

Much has been said about the important contribution of the Community Health Aide in improving the health care delivery system. Suffice it to say, that given the different life-styles of the nurse and the patient, the Community Health Aides role is crucial in closing the gap between the two.

In looking at the relationship of Health Maintenance Organizations to nursing, it is important to understand that "primary care, one of the keystones of the HMO, emphasizes those services aimed at preventing the onset of illness or disability, at the maintenance of good health, and at the continuing evaluation and management of early complaints, symptoms, problems and the chronic intractable aspects of disease." Specifically, what this means is you want to reduce the number of patients who need hospitalization as well as reducing length of stay in a hospital. It seems to me that it is here that the nursing team functions best. Let us ask ourselves what causes patients to be hospitalized and often for long periods of time.

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In a community such as Mile Square, the answer is a multifaceted one. Individuals are alienated from the large impersonal hospital, often do not understand or trust the care offered to them. Consequently, it simply is a case of too little and too late-too little preventive medicine and too late for simple treatment-for most residents of the community.

The Nursing team functions to ameliorate this condition. Perhaps one or two case histories will be illustrative.

In the case of infant mortality, the most important preventive measure is to get the pregnant individual to register for early prenatal care. There are various ways we accomplish this: (1) informally through word of mouth, (2) by advertising prenatal classes, and (3) through screening of Adult and Pediatric patients.

Let me elaborate-it is important to understand that in low-income communities the efficiency of the grapevine as a means of communication is not to be underestimated. Clearly, nurses and physicians, most of whom are white and do not reside in the community, are not part of the grapevine.

If the Health Maintenance Organization is to be successful, it must rely on community trained persons as health aides (and who are already part of the grapevine) to establish contact and disseminate information. In short, Mrs. Jones usually knows who's pregnant and can be relied upon to inform her health team. She then might, in the course of a day, pay a friendly visit to the pregnant individual and in conversation encourage her to come and register for prenatal care. For a white nonresident of the community to think she can randomly knock on doors and be successful is futile in if not all, the vast majority of cases. However, success often is measured in small steps. For example, while we feel pleased with the fact what we have reduced the infant mortality rate for our registered patients to 36.1/1000 live births we are still faced with reaching the hard-core individual who has yet to register. We still need further analysis to determine why some individuals readily become patients and others do not.

Another example of how the nursing team functions has to do with our policy of having nurses visit both in the home and in the hospital. It is very important to build into your nursing program what we call a "continuity of concern." By this we mean, that the patient can rely on continued support from the health team. We have found that having a team member visit the patient while hospitalized does much to allay both patient and family anxiety. Very often a patient's reluctance to be hospitalized is reduced because of her knowledge that she will be visited by someone she knows and trusts. It also means that the patient is willing to return home sooner again, because she can rely on home visitations.

For similar reasons, we have been successful in reducing the need for and length of hospitalization for our geriatric population.

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Our studies indicate that generally fewer of our patients are hospitalized for shorter periods of time. We attribute this to the success of the nursing team.

Some problems to be anticipated. I strongly feel that the degree to which we have been successful can be attributed to our ability to take our problems. In spite of what I have said today, all is not rosy all of the time.

Some of the problems you must be prepared to treat are: (1) the difficulty in recruiting and keeping nurses. Until nursing curricula do a better job of preparing nurses for working in low-income communities, the turnover rate will remain a serious problem. (2) Given the high status position of physician in society today makes it extremely difficult (if not impossible) to develop a coprofessional relationship between the nurse and the physician. To the degree that you cannot do this, the team concept is weakened. Time and again I have found physicians willing to pay lip service to the concept of the team approach only to have them fail on an empirical level. (3) Last, but surely not least, is the absolute need to understand the radical changes many black communities are experiencing. In my opinion, the greatest strength of a Health Maintenance Organization is in its ability to enter into an equal partnership with the community. A cursory look at some of the problems many Neighborhood Health Centers are encountering reveals the nature of the problem to be a desire (indeed demand) by the community for greater autonomy and power. The Health Maintenance Organization design allows the community to pick and choose which group it chooses to contract with. Hopefully, the contract will spell out the nature of the relationship so that this problem is eliminated.

In summarizing and concluding I hope that I have made it clear that we are dealing with a large complex problem. I have attempted here to treat one aspect of the problem, namely the role of nursing. I have tried to emphasize the need for adherence by all concerned to the team concept.

This concept includes nurses, community health aides, and physicians working cooperatively in understanding what is necessary to render meaningful health care to a low-income population.

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On the first day of the Conference, conferees were asked to write a brief statement describing "What is your concept of an HMO at this time?" at two different times, first, as a pre-test at the beginning of the day, and second, as a post-test at the close of the day. The answer sheets were color coded as noted in the headings which follow.

PRE-TEST (on pink sheet)

HMOs (Health Maintenance Organizations) are new initials in the health care field. They are the Administration's response to the growing cirsis in American health care. Discussed in the President's Health Message to Congress on February 18 and incorporated in H.R. 5615, HMOs already are being promoted by HEW before new legislation is enacted. The central concept includes capitation or prepayment. On the delivery side, prepaid group practice is identified as one form of HMO, but many other arrangements are possible under present proposals.

HMO, my concept - Organized health services in a particular area or district offering every patient an equal opportunity to choose to get better comprehensive health care. This system will include all dimension, prevention, health maintenance, illness, and rehabilitative services. Delivery mechanisms to include hospital nursing and home care delivered by many health disciplines.

HMO - What is it? A concept of a Health Care Delivery system that would take care of the health needs of all the people from birth to death in a given community.....

HMO is a system of health care delivery aimed at capitalizing on the strengths of preventive medicine, group practice and the hospital as related to integrating the first two factors mentioned.

Knowledge of:
1. Structure and operation of HMO
2. How an HMO is developed
3. Different types of HMOs
4. Where Wisconsin is in developing HMO
5. Kinds of health workers needed; education preparation of workers
6. Who controls HMOs - how? Where do state departments of health fit into "policing" policies and level of care and services?

1. Insight into delivering health care to <u>all</u> people
2. Knowledge of HMO
3. Concepts being developed by HMO
4. Insight into what an individual can do
5. What HMO is doing in Wisconsin

Health Maintenance Organization is an organization of health services which will have as its functioning objective the maintenance of health which is inclusive of preventive, acute, ongoing and

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rehabilitative care for the consumer. The consumer in turn accepts this, having subscribed to a preplan payment as an insurance plan.

A health maintenance organization is a prepaid (generally) organized group of health professionals who have a basic aim to keep people healthy and treat early illness as opposed to a crisis type of medicine.

HMO concepts - These are when organizations which focus on preventive and maintenance rather than the traditional curative, care concepts. Where individuals seek health assistance and stay well or seek help at earlier periods of detection rather than the curative illness approach.

Health Maintenance Organization has these characteristics:

1. Organized as prepaid group practice usually
2. Payment in advance for a broad range of health services usually of a capitation basis
3. Financial incentive on keeping persons well
4. Emphasis on health maintenance instead of pathological orientation
5. Intended to alter the emphasis and mode of the health care system
6. Emphasis on keeping persons out of high-cost institutional care
7. Being promoted by present material administration as most plausible way of responding to present health care crisis

Health Maintenance Organization is a system of providing health care on a fee basis through community effort by physicians and other health professionals.

Primarily a financial mechanism for prepayment of health care. As I have reviewed the materials, there is little in those that exist for preventive care as well as for maintenance. This concept really should be changed, if HMO is to provide a change from what now exists.

Health maintenance organizations would provide an effective means for delivery of health care. At present, we operate primarily on crisis intervention and spend all of our time on therapeutic measures. It cannot be denied we shall always have need for therapy, but we could prevent many of the crises through preventive measures. The HMOs would give all members of health team an opportunity to use their know-how in a coordinated manner.

Health Maintenance Organization is a system of health care delivery resembling socialized medicine. It is an organized community approach taking initiative in delivering health care economically and efficiently in areas where the individual practitioner has only had a limited interest, that is, interest in his own practice or his own segment of hospital service. HMO appears to me to place control in a third party, the government or an authoritative-appointed local committee. I wonder if structure of health care delivery is a problem-or if it resides within the education of practitioners for these areas. I don't see where reorganization, structure can solve professional images,

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stereotypes. So I question how HMO concept can solve anything except producing dialogue--a good topic to talk about.

A health maintenance organization has the responsibility for providing prepaid continuing and episodic comprehensive health care to its enrollees.

HMOs are duly organized, incorporated businesses to provide total health care--preventative, restorative, maintenance care to an identified group of persons; sunder services to assume total responsibility for provision of above services.

Methodology to provide comprehensive health care services, preventive, outpatient, inpatient and rehabilitative to an individual or group on a prepaid insurance basis. HMO will be financed on a capitation rate in a continuing manner and must provide total services to enrollees. It can make $ only by preventing illness.

Health maintenance organizations are organized on group medical care plans which provide complete medical care, including prevention for individuals and families on a prepaid basis. The concept is to keep people well, as well as caring for the ill and giving treatment. HMOs are comprehensive prepaid medical care.

HMOs are group health practices wherein members or subscribers receive all of their health care in a one-stop center, both in-patient and out-patient. The center attempts to reduce in-patient hospitalization days by maintaining the health of the members at a high level. Practitioners are employees of the HMO. Subscribers are usually employees of an employer who pays the cost of care at an HMO through insurance premiums as a fringe benefit for the employees.

My concept of a HMO is a group of physicians who have incorporated and arranged with an insurance carrier to provide health services for subscribers for a specific annual insurance fee.

HMO--A health care complex which provides a continuum of comprehensive care from prevention and case-finding through curative, rehabilitative and continued post care-primary care.

A Health Maintenance Organization is an organized system of health care that agrees to provide a comprehensive set of service to an enrolled population at an agreed-upon annual cost. The emphasis of the program will be placed on prevention.

A Health Maintenance Organization provides comprehensive health care, i.e. preventive, curative and rehabilitative, to those persons enrolled in the organization on a prepayment plan. The service would be provided in the clinic, hospital, home or extended care facility.

An organized system of complete health care--an individual prearranged payment system. Group enrollment.

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Any organization can form an HMO providing it has a group of doctors to supply the medical care. (1) Apparently no provision for monitoring the care offered, and funds not used in patient care may be returned as profit by the sponsoring group. Thus under-care is possible. (2) Doctors are told they may have the same concerns before. (3) So far no stipulation, I believe, that the doctor groups will be multispecialty. Thus danger that patients of a g.p. may not be referred to a specialist. (4) No limit on number of HMO in an area. Thus oversupply.

A contract arrangement whereby a patient can arrange, through an organized system, for all needed care, with emphasis on preventative and ambulatory care.

HMO is a health care financing concept, based on the payment of capitation for services rendered. It incorporates Phy and Hosp in the providing of care.

Limited knowledge of "HMO"-Kaiser Foundation prominent in California. Began in late 1930's and expanded tremendously during World War II--it appears to me, that this was Kaiser's method of keeping his employees on the job, and to provide health care for his employees at the lowest possible cost.

A newer concept in the delivery of total health care to meet the health needs and health maintenance for all people. A promotion of a higher level of wellness without undue concern for the cost of being well. An attempt to deliver better health care.

The HMO is an organized system wherein persons by paying a fixed amount will be able to obtain prescribed health and medical care on a continuing basis. The system will provide the medical and institutional care for the enrolled persons.

The HMO concept is one which embodies the following:
A medical care system that provides complete health promotion, preventive, curative, and rehabilitative services to a group of consumers who are covered by a group health insurance plan. The care may be provided in a variety of ways and settings, e.g. neighborhood health centers, group practice or other organizations. It is the point of entry into the health care system for participants.

An organization that is developed by providing for and with consumers who will be receiving health care in an organized comprehensive manner by a multidisciplinary health team. The term HMO is still new to me and I hope this conference will increase my understanding of this term.

HMOs are an attempt to meet the disease prevention and health promotion aspects of the health needs of people. Currently the health delivery system places much attention to the needs of the sick while the maintenance of health has been largely ignored. HMOs are an attempt to alter this situation.

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HMO is a system of comprehensive, continuous health care, both generalized and specialized, acute and long-term care, in-patient and ambulatory delivered by a multidisciplinary health team and financed by mechanisms of prepayment.

Health Maintenance Organizations--a system by which patients can prepay for health care; the organization may be through medical group practice, individual practice. I can see no reason why neighborhood health clinics, community hospitals or public health units cound not be the primary organization.

These are groups of professionals of all health disciplines, medical, chiropractic, osteopathic, optometric, etc. working together as a unit for the benefit of the health consumer. The services provided are predetermined and programmed by each group of individuals.

An organized, interrelated system of Comprehensive Health Services available to a voluntarily enrolled population financed by a prepaid annual charge.

A comprehensive array of health services with emphasis on prevention and maintenance of health, provided by a team of health workers to a voluntarily enrolled group of persons who prepay for this care through a capitation arrangement

To provide a Comprehensive Health Care program to the consumer at a price he can afford.

It is a prepaid health system that a person may join voluntarily to secure complete health care. Geographic boundaries form the limitations of the group. Physicians practice on a prearranged financial basis. Emphasis is on preventative and outpatient care.

An organization which does the following:
Provides comprehensive health care on a prepaid basis.
Encompasses hospital care, outpatient, and home care with the type based on the needs of the patient.
Personnel and facilities are utilized efficiently depending on patient needs.
Preventive medicine is practiced along with curative medicine.

HMO--a system to provide broad health maintenance and sick care services--flexible in organization--to fit local resource and combine partnership of users, suppliers and economic supporters.

A health care delivery system providing comprehensive care to a defined population financed by some form of prepayment.

An organization developed for the delivery of comprehensive health care to defined population for a predetermined fee. This fee may be determined on a capitation basis or a community group basis.

A preventive health care organization designed with a prepaid

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program inclusive within the HMO concept.

Organized system of health care delivering preventive and treatment of health services involving various providers.

A health organization providing comprehensive health services to individuals and families, supported by a prepaid insurance.

A relatively new concept in providing health care. Emphasis on primary health care--preventative and rehabilitative services through health education and better follow-up and emphasizing team approach through basic HMO. Community or area organized program--central coordination--group membership to system. Attempting to reduce health care cost to patient and yet maximize community health care services

An HMO is a prepaid health system. It provides the oppoutunity for people living in a geographic area, to secure health care by participating in the prepaid system--the system utilized all types of health care facilities and manpower.

A program to encompass all phases of health delivery to the entire population. This program includes all health facilities and physicians which will work together to provide a more economical and professional delivery of health.

A formalized organized structure of prepaid medical care--to include ambulatory care as well as acute and major medical care. It may include several health facilities and/or one facility offering all services.

An organized effort to utilize the services in a coordinated and meaningful way to provide comprehensive (if possible) care to people. Thus making it possible to lessen fragmentation, gaps and excesses distribution to serve as many as possible.

Delivery of the best possible and most modern health care to all people who need it regardless of race, creed, color or economic status. Most efficient and less costly method of delivering health care.

HMO is prepaid group health insurance for voluntary subscribers; supposed to cover all medical needs, preventive as well as acute health problems. Basically, a method of payment rather than a reorganization of delivery system. Private groups or public agencies or institutions may become HMOs. Favored by MDs as HMOs really produce little change on delivery system or MD autocracy.

Health Maintenance Organization means to me an effort to design a delivery system(s) for promotion of positive health--providing incentives for health professionals to move beyond current emphasis on "unwellness."

Health Maintenance Organization is a means to articulate components of the health care system in the interest of securing a balance in

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preventive, acute care, rehabilitative, and maintenance components for consumer. It implies accessibility of services and a quality level which secures desired outcomes.

Health Maintenance Organization is concerned with preventive aspects of health as well as curative aspects. Emphasis is on health rather than on illness. Purpose is to keep individuals healthy.

Health Maintenance Organizations are those aggregates of services (preventive, treatment, and rehabilitative) which are grouped together for the purposes of providing health care for a defined group of people. The organization includes private vendors, care facilities, payment mechanisms and consumers. Control is vested in a combination of consumers and providers.

Health Maintenance Organizations are intended to provide, through subscriptions of individuals and families, a continuing, effective method of health care delivery. This is a service outside existing traditional services--viz, hospitals, health departments, clinics, etc.--but is a new concept of providing for all health needs on an out-patient basis.

Concept of health service delivery organization (various possibilities) geared to prevention, etc. Prepaid type of care. Private group etc. (many ways), etc.

A health maintenance organization is a system of health care in which illness prevention and promotion of optimum or maximum is the objective. The work of the organization is carried on primarily on ambulatory, out-patient basis. Hospitalization is used only for health situations that actually demand this type of expert care. The HMO would concentrate on good utilization of health professionals of all levels and varieties of preparation.

The essential components of an HMO are: (1) a defined population to be served (consumers of health services); (2) a voluntary grouping of medical and paramedical personnel organized for a committed to, serving the defined consumer group; (3) a financial arrangement which covers settlement of such factors as, (a) range of services to be offered, (b) fees to be paid (either by the consumer, or firm, or shared, or government in cases of poverty, etc.) through a centralized third party such as an insurance company; (4) a continuum of services spanning preventive to curative care.

HMOs are furtner characterized by a nonuniform approach to formation. For instance, a college of medicine attached to a university could initiate an HMO--a labor union--any group of concerned citizens, etc.

A community-based organization to provide health care for its citizens. Crucial question is how in a country where individuality is rapidly diminishing this is to be accomplished without additional loss of individuality for both provider and user of services.

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HMO is a program of delivery of Health Care to all persons. Subsidized by a third party payer which through prevention of disease would eliminate the high cost of hospital care. It is a self-contained unit.

Included in HMO concept:
prepaid (incentive to control costs)
group practice
medical-surgical care
regular check-ups
use of automated screening, histories, records
emphasis on prevention, early diagnosis
Still lacking:
health promotion
environmental control

A health maintenance organization provides the complete spectrum of health services to an identifiable group of people on a 7-day 24-hour basis for prospectively determined rates submitted on a prepaid basis.

Organization of Health Care Services for Voluntary participants - in specific geographic area - "Comprehensive" in nature - inpt., outpt. - rehabilitation, emergency. I'm here to discover what this concept provides in terms of specific programming for mental health and psychiatric care services. How it compares and/or relates to Community Mental Health concept and implementation.

Organization to provide health care services to:
1. a specific population - at present generally within a certain area,
2. for a certain, predetermined cost: a comprehensive coverage that is broad rather than of a fee-for-service,
3. defining the services that will be provided - physician, out-patient, hospital, etc. with emphasis on prevention as well as care during illness.

An organization in which a group of individuals through prepaid insurance receive health care both preventative and therapeutic and rehabilitative from a group of health professionals.

Health Maintenance Organizations represent a reorganization in the delivery of health care services. The consumer enrolls and pays in advance for his health care. In return he receives care to meet his health needs on an in-patient or out-patient basis.

A means of involving the communities--regionally to help with prevention of disease, provide health care to all, involved with health care delivery--ways and means.

HMO to me means the concept of interdisciplinary and interagency planning and programming to meet health needs. However with the autonomy and vested interests of health agencies I am at a loss to know how it will come about.

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A proposal system of care in which emphasis

1. On wellness and prevention of disease is paramount. The departure from focus on illness is the distinguishing characteristic.
2. A system of health service delivery for all citizens.
3. The concept is reasonably well defined and articulated. My concern, however, relates first to the modalities of delivery and then to the change needed in how professionals and laity plan for health care and educate its practitioners to deliver and evaluate health care and comprehensive coverage.

Health Maintenance Organization can be system of providing comprehensive care, preventive and acute, and chronic, to a designated number of people or population through insurance payments--payments may be made for some groups by Medicaid, Medicare, OEO and for some by the private incorporation.

Health Maintenance Organization is a [way] for delivering Health Care, organized as a group practice to deliver health care for preventive medicine improvement. The fee basis is to be prepaid as opposed to fee-for-service. In HMOs many of the practices previously performed only by MD's will be performed by allied health professionals under supervision of the physician. Hopefully, (a) HMO will be at the forefront of immature programs in health care delivery with the help of Health Maintenance rather than the practice of "too late medicine"; (b) the consumers of health care will play a major role in the dynamic making of their HMO, i.e. consumer control is at least important; (c) the training and health education.

HMO concept - to develop comprehensive patient (family) care for a given or designated population via a prepaid financing plan. Its focus is on primary or ambulatory care (both treatment and preventive medicine) but I would encourage there will be affiliation with hospital for the provision of inpatient and backup services.

HMO concept - provide comprehensive health care to people through a prepaid plan for health care. Should include preventive aspects--care of acute services, emergency and otherwise, hospital care services, home care services, and custodial care service to other illness clients, and all the supporting sources, i.e. laboratory, Xray, etc.

HMOs would include many and varied organizations concerned with promoting the emotional and physical well-being of the entire population. This may be medical, nursing, sociological, economical or research oriented.

An HMO is an organization for the total health care of a subscriber. It is concerned with maintaining the subscriber's health. It includes primary care, prevention, dental, psych, chronic nursing care, and rehabilitation, (Some so called HMOs may not be as comprehensive.) It includes all the personnel--doctors, hospitals, etc. It exists on a prepayment basis (usually).

An HMO is an organization which delivers comprehensive prepaid health care, with emphasis on the preventative aspects of health care, with an annual dues structure computed on a capitation basis.

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POST-TEST (on blue sheet)

An HMO is an organized system of health care that attempts to provide a "comprehensive" set of services (SX and RX) for a voluntary enrolled group of persons in an identified geographic area. The emphasis of care is placed on prevention, primary care for previously agreed upon fee (usually annual).

A health care system which offers a continuum of comprehensive health care to an enrolled population for an agreed-upon capitation fee, prepaid.

HMOs - newer understandings:
Diversity in organizational structure is possible. Financial resources and funding vary. Emphasis on prevention is heartening. Appears to be a lack of understanding as to how registered nurses can function effectively in HMOs.

My a.m. opinion re essential ingredients remains unchanged:
1. providers of health services (comprehensive) organized in group effort,
2. recipients of services within organized group,
3. some kind of prepay to mechanism (third party or otherwise).

Major features evidencing departure from current non-system:
1. solo ——→ group practice
2. postpayment (following service) ——→ prepayment
3. coverage of wider spectrum of services (emphasis on ambulatory and preventive care)
4. co-ordination of components

The day has highlighted for me more how reality in existing HMOs differ from my personal dream of what an HMO could be. The descriptions appear to be highly medically, symptom-oriented programs with possible exception of Miles Square. Discouraging potential for developing what would seem to be possible in prevention.

An HMO is any organized system of health care and treatment for a specific group who voluntarily agree in advance for a fixed prepaid amount to utilize this service for comprehensive health care, including prevention.

My concept of HMOs has not really changed that much from the earlier statements. The one thing I continue to be concerned about preventative services and maintenance services is the continuing emphasis upon curative medicine. Also the continuing poor utilization of the various professionals in this as well as the current delivery system.

An organization which is prepared to deliver a broad spectrum of health care, to an enrolled population, financed largely or wholly on the basis of prepayment or capitation. The emphasis is placed on preventative and ambulatory care, rather than the cure of acute illness.

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HMO - a complete health care for a fixed group of the population on a prepaid per capitation basis with the objective of preventative medicine.

My concept of HMOs has not been particularly changed today. I feel the speakers have cleared several co-beliefs from my thinking. However some HMO problems (as I see them) appear more obvious:

1. Lack of role understanding and appreciation between doctors and nurses.
2. Lack of preventative services.
3. Lack of dental and glasses.

There are several different kinds of HMOs all of which offer a wide variety of coverage. The most comprehensive still appears to be the neighborhood health center. Use of nonphysician personnel for primary care is an obvious gap.

A relative new health care delivery system, more versatile than the present one. A reimbursement system basically the same as our present, but somewhat lower than insurance companies.

It is a prepaid program of health care for which the consumer receives coverage of health costs at agreed-upon levels. Its emphasis is total care and savings through efficiencies based on a system that encourages preventive and immediate care.

Any organized system of health care that provides for a full range of services to an enrolled population in return for a fixed sum of money agreed upon in advance.

HMO--comprehensive prepaid medical care delivery system rendered to a given or designated population.

HMO is a loosely defined organization providing a spectrum of health services to a specific group of people for a fixed prepayment fee.

HMO--any organized system of health care, delivering a full range of health services which has a voluntary population which enroll with the agreement of paying in advance for the care they may receive. The HMO has the responsibility to provide services. Included in the philosophy of most HMOs is "preventative" health care as a goal--maintaining health not just caring illnesses.

A comprehensive program of health care geared for all persons who subscribe to such a program and affording care that can be given at a price a patient can afford.

HMO--prepaid group health arrangement to provide comprehensive medical (should be health, not just medical) care to a voluntarily enrolled population. HMO may take many forms--public, private, or combination. Emphasis on prevention of illness as a means of keeping costs down.

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HMO is an organized system of health care which is comprehensive and prepaid for a defined population where there is voluntary, enrolled participation.

HMO is an organized system of health care for a specific group of individuals in a geographical area. All aspects of health care emphasize on preventive care to reduce cost as well as prevent serious illness.

See HEW handout Health Maintenance Program: The Concept and Structure, page 1. My understanding did not increase, merely sharper.

HMO is a system of prepaid, contractural health care with an emphasis on prevention and early care which utilizes in its delivery, a variety of health professionals and assistants and thereby assures the recipients of all levels and degrees of diagnosis, care, etc., in whatever environment they happen to be.

My original definition did not include the prepayment aspect.

Concept of type of organization (system) of Health Care Delivery, providing a variety of services and based on prepayment arrangements. Ideally emphasis on prevention and early detection and geared (hopefully) to consumer education. There are numerous and varied types of structures possible. Hopefully the variety of services will be comprehensive in nature!

Health Maintenance Organizations are characterized by their commitment to provide a wide range of services to a group of individuals who are covered by some form of insurance or financing that make the care possible. There is great variety in the way in which HMOs may be organized from neighborhood health centers to group practice. HMOs provide entry into the health care system.

An organized group that provides comprehensive health services to a voluntary group that have had input into services provided and have prepaid the organization for this care for a specified time. Understanding between providers and consumers as to what services will be provided. Policyholder receives care as needed and when needed.

Concept of morning comments - essentially unchanged.

Same understanding - but interesting to get information firsthand from those involved.

No actual change in concept. The discussion did add some detail of how HMO have been organized and how they function.

HMO--An organized system of health care that provided a full range of health care service through a fixed prepayment plan.

HMO is an organized system of providing medical care to a voluntary defined population. An HMO can be organized in various ways and may provide a variety of services, prev, prim and chronic care (sick).

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I have heard a definition of HMO and gained more of an understanding of its functions. Many questions have arisen in my mind which I do not readily see an answer for. To enumerate, these are:

1. Will quantity of people cured for decrease quality?
2. Who will put controls and set standards for HMOs? Will this be at a state level or the national level?
3. It greatly concerns me that individualization will be lost in a corporation-type care facility. We're a fast-paced society and sometimes all people need is someone to listen to them. Will this be lost in the system?

Existing HMO's - apparently functioning according to my previous ideas, except with less emphasis on keeping the employee on the job. HMOs operated as a "business," not too unlike some non-HMO health facilities. Utilization of Nursing Manpower at Seattle Group Health Coop sounds highly inefficient.

Dr. Ellwoods hopes for future HMOs meaningful and practical (realistic).

A system of organized comprehensive continuous services, generalized and specialized, acute and preventive delivered to a specified population of voluntary enrollees and utilizing mechanism of prepayment for support.

HMO--no use of community resources. So an entire community in itself and serves all needs within its structure. Takes responsibility for training its own personnel. Prepaid protection is for promotion of wellness rather than the treatment of disease. Use nursing for health teaching in a more effective way.

I think I had the concept prior to today. I still feel there is much to be done in the area of prevention and education. I have some difficulty in seeing a great difference from today's practices except for method of payment.

HMO is a system of providing comprehensive health services--treatment and maintenance to families who select it on a voluntarily and prescribed fee basis.

I see Health Maintenance Organizations as voluntary comprehensive health care insurance in which the subscriber can look for promotion of his optimum health and prevention of illness. He can expect quality care because of the presence of at least some competition for his subscription.

A HMO is an agency that provides specific health care benefits for a specific group of persons (enrollees) for a specific fee which is prepaid.

I can't say that I've changed my idea too much. I understand the organization a bit better.

Health Maintenance Organization--the same as my pink sheet

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definition with the addition of information about the forces of manpower rising from the manner of health service system.

My concept of HMOs has not changed, but I have a better understanding of how they are organized and function. I need more information on legal obstacles, method of initiating.

I did not change my ideas about HMOs but they were greatly enriched, especially through Dr. Ellwood's presentation. The present forms of HMOs seem limited in the area of prevention for the most part.

HMO is a system of delivering health services initiated by insurance companies, or doctors, or consumers (union groups), or hospitals. It is initiated on a local level and where I previously thought that the government was a prime mover in this system I find that there are few controls and financial incentives offered by the government. The multidisciplinary approach offers a chance for consumer control to avoid HMO being a monopoly by any particular party in the system (primarily doctor control and oriented).

HMO is a comprehensive system of health delivery which provides a comprehensive program of care to a specified group of people for a preset fee.

HMO--an organized group who provide treatment and prevention health care for a specific subscriber group for a specific fee; paying for a preplanned program.

My definition remains the same. I did some prior reading. The only aspect I forgot to include is the prepayment arrangement.

I would offer essentially the same definition as given initially because of previous information about HMOs. (This is not to imply that I did not enlarge my understanding of HMOs today. It has been a very informative, stimulating session.)

The HMO is a beginning - there is still much to be done! Much keener studies must be done to practice preventive medicine rather than curative medicine.

An organized system of comprehensive health care to an enrolled population, fixed sum of money agreed upon in advance.

An organized system of prearranged and agreed-upon comprehensive health maintenance and care services provided by a group of health workers (team concept) to an enrolled population on a prepaid per capita fee basis.

HMOs are a means of providing comprehensive health care to a voluntary population of enrollees agreeing to a fixed price for prepaid health care and maintenance. Emphasis seems to be on eccouraging enrollees to seek preventive care and providing comprehensive health care at a lower cost.

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IDENTIFYING NURSING CONCERNS AND THE NURSING ROLE AS RELATED TO SERVICE AND EDUCATION IN THE DELIVERY OF HEALTH CARE VIA HMOs

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The Health Maintenance Organization concept should be viewed as an opportunity to improve the quality of care with a commensurate reduction in the cost of such care. This concept emphasizes comprehensive care and provides for a better integration of preventive medicine with curative medicine. It holds the promise of changing the economic base of medical care from that of fee for service to a capitation basis. This latter move would not only reduce the cost of care but also permits a better utilization of health manpower. Inherent in the HMO concept is a "one door" system for care which should provide greater opportunity for the effective functioning of interdisciplinary teams.

However, much of the thinking on HMOs is still at the conceptual level and very little has been written about the details of implementation. I firmly believe if certain strong external guidelines are not consistently laid down and followed in the implementation process, then not only may the preceding benefits be negated but additional problems could ensue.

For example, it is repeatedly stated in the HMO literature that the quality of care will be controlled through competition and consumer demand. However, if a given area has a scarcity of physicians and if the few physicians in that area chose to develop an HMO, then not only will there be no competition, but a monopolistic system will have come into being with little input from the consumer. This situation could perpetuate low-quality care with only the façade of a new organizational structure. Even in those areas where there is an adequate supply of physicians the competitive system is not always effective in bringing about improvements in the quality of care. For example, a large prepayment health plan in California which is often cited as a model for the HMO concept recently conducted a study of one of its centers and found that because of dissatisfaction with the quality of care, 40 percent of its members used other existing health services in addition to the prepayment plan. They only used the health plan's clinic for major medical services and chose other sources for primary care. This situation was never reflected in the enrollment in the prepayment plan since the consumer was willing to bear the burden of supporting several different sources of health care.

One of the major strengths of the Neighborhood Health Centers sponsored by the Office of Economic Opportunity has been the consistency with which that agency has insisted that certain guidelines be followed relating to comprehensive care and consumer participation. It seems equally important that Health Maintenance Organizations be required to follow certain criterion in order to insure standardization of care.

Whether or not HMOs become the universal system for the delivery

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of health care, certain trends are already developing which have implications for nursing and require close scrutiny.

The trend toward increased services in ambulatory care with an accompanied diminution of in-service care is already apparent in certain parts of the country. Many hospitals are reporting an occupancy rate varying from 50 percent - 70 percent, while at the same time their ambulatory care services have tripled. In the past, bed occupancy rate has porvided the basis for obtaining matching funds for support and also for determining staffing needs. Many administrators are now realizing that this is an antiquated basis for assessing such need. An important question nurses should be asking themsleves is, What effect will this new emphasis on ambulatory care services have on the function and role of nurses? If nurses are not in large demand for in-service care, how will they be absorbed and utilized in out-patient services?

There is inherent in the HMO concept a dedication to improving the efficiency of the delivery of health care. This is a commendable objective and many recent studies have documented the lack of efficiency in our present system. However, will there be an appropriate balance between efficiency and effectiveness?

This question has particular meaning for nurses because they will be asked as never before to be accountable for their services and if they cannot demonstrate a contribution they will be replaced. This trend is already reflected in some states where nurses are finding themselves among the unemployed with little or no demand for their services. For example, in the Bay Area of California, nurses with the help of the CNA, have been very effective in raising their salary scale to a substantial level. Some of the prepayment health agencies using a cost benefit approach found that nurses were functioning in their out-patient departments largely as clerks and traffic managers. They decided that these nurses could be replaced by other types of workers who would receive a lower salary and probably function just as effectively. Presently this group is only hiring nurse practitioners for its ambulatory clinics. Nurses are undoubtedly performing other functions than that of traffic managers in out-patient departments, but all too often there is little visibility of these services and the nurses have never documented their additional tasks.

We have made certain assumptions about the effectiveness nursing service has on health outcomes, but these assumptions have seldom been tested. For example, it has often been stated that home nursing services for the chronically ill will curtail the clinic and hospitalization needs of these patients. Yet, a study conducted by Dr. Katz on the effect of home nursing services for patients with rheumatoid arthritis showed the number of clinic and hospital visits were actually greater in those patients receiving visiting nurse services, but these patients had a much better result with respect to "Activities of Daily Living" than the matched control group. If nurses were selling their contribution on the basis of cutting down hospital visits they would not be considered effective, but if they were selling themselves on the basis of increasing the productivity of their patients then their contribution would be evident.

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The trend toward a more effective use of interdisciplinary teams in giving health care is already influencing the administrative structure of many agencies. In several state and local health departments, a separate bureau of nursing has been dissolved and nurses are assigned directly to programs. Although this trend might be threatening some nurses, it provides the opportunity to break down some of the existing barriers which have prevented a variety of disciplines from effectively working together to meet patient needs.

All of these trends have implications for nursing education. We must make it more relevant so that we are preparing graduates who can effectively adapt to a changing health care system and make significant contributions to individual and community health needs.

The many problems that might ensue in establishing Health Maintenance Organizations or other types of health care organizations should not make us withdraw our support of such concepts. Instead we should identify some of the underlying issues and study them so that there will be positive input into their development on the part of the nursing profession.

The purpose of this workshop is to begin to explore some of these issues. Several questions have been devised for explanation, but I hope you will not limit your discussion to these questions.

QUESTIONS FOR DISCUSSION - IMPLICATIONS FOR NURSING IN HMO CONCEPT:

1. How will the change in emphasis from in-service care to ambulatory care change the functions and roles of nurses?

2. What implications will these changing functions and roles have for Nursing Education, Baccalaureate, Masters' and Continuing Education Programs?

3. What effect will the increased emphasis on efficiency have on the nurses' need for accountability of her services and contributions?

4. How will the HMO concept affect the organizational patterns of Nursing Administration? If there is no longer a separate nursing division, who will the nursing personnel relate to and in what manner?

5. What should be the input of nursing into HMO development? If nurses have not been asked to participate in such development, how can they create opportunities to be certain they are involved?

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GROUP WORK LEADERS

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GROUP WORK REPORTS

Health Maintenance Organization: Concept and Functions

Group I

Recorder: Ruth Reifschneider
Leader: Hildegarde Siegel

Group I elected to explore the roles and functions of nurses in HMOs since these seemed central to other discussion areas. Several levels of nurse participation in HMOs were identified:

1. Little, if any, involvement of nurses.
The group wondered how accurately this lack of involvement might reflect the present status. In some regional conferences regarding HMOs, almost complete disregard of nursing occurred. If HMOs develop with a range of other workers such as physician assistants, health aides, physical therapists, nutritionists, etc., it seems conceivable that one alternative might be the omission of nurses if they have not been able to document their professional and economic contributions.

2. An inappropriate level of nurse participation.
In this level of involvement the nurse was viewed as a receptionist, hostess, injection-giver-an assistant with subprofessional tasks. The group rejected this caliber of nursing contribution but recognized that it does exist and is so described in some existing HMOs.

3. A collegial relationship with other involved health disciplines.
In this participation level the nurse would be involved in the planning, implementation, and evaluation of the HMO. Implementation would include both direct and indirect services to enrollees. The nurse would function as a practitioner. Her activities would include interviewing and health assessment; primary care; referral; continuity of care; coordination of care; education of groups, individuals, professional and paraprofessional workers, and the community; supervision of all levels of nursing care providers; counseling; preventive and restorative care; and so on. Participation is not confined to implementation of care, but meaningful roles in planning and evaluation of that care are integral. The key role of the nurse was seen as the consumer advocate. She was regarded as uniquely prepared to represent and pursue the health interests of the individual and collective consumer. Her efforts should extend to the elimination of health hazards in the social, emotional, physical, and economic environment.

The role of the nurse in the setting described above was viewed as flexible, versatile, changing, interdependent. She must be concerned that the needs of the consumer are met, not defensive about professional boundaries.

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4. A founder of a nurse-organized HMO.
   The nurse would assume responsibility and accountability for the health care of the enrollee. Medical care, as well as other services, would be obtained by contract or by inclusion in the organizational composition.

Questions evolved by the group included:

1. Who represents nursing in decision making in current HMO activity, particularly at the national level?

2. How can nursing obtain the information and answers needed about the HMO movement in order to get involved nationally and locally?

3. Is the HMO concept fuzzy deliberately? Is it a ploy to forestall national health insurance?

Recommendations for nursing education:

1. Faculty should have experience in current delivery care systems and locations of practice.

2. Expected and experimental, rather than totally traditional, settings should be utilized for clinical experience.

3. Students should learn about the social substructures within which they will function.

4. Baccalaureate and master students should have advanced study in social structures and systems, and implementation of the change process.

5. Present nurse practitioners need continuing education to assist them to meet increased responsibilities for health evaluation, health maintenance, and continuity of care.

Additional areas for action:

1. Involvement of the professional organization in formulation of the role of the nurse in HMOs and in assuring nursing input in the development of HMOs.

2. Removal of licensure restrictions that stifle the role of nurses.

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Group II

Recorder: Sarah S. Detmer
Leader: Geraldine Wojtowich

Initially there was an attempt to deal with the issue of defining to clarify and visualize implication for nursing in HMO concept.

1. Utilization review:
   Is it medical utilization or is it patient care oriented?
   Nursing should have a role here.

2. Primary ambulatory care:
   Where does it happen now through nursing--not in most HMOs? In neighborhood health centers and selected outpatient settings?

3. Nursing role:
   What are the expectations of the public, the physician, and the nurse?
   Is the nurse who is giving primary care a physician's assistant?
   How does she differ from a physician's assistant?

Nursing and medicine are both resistant to change in roles. The PNP programs have met with resistance but are now enjoying greater acceptance because nurses have demonstrated competence in this role.

It was the choice of the group to focus on the question:
If the nurses have not been asked to participate in the development of HMOs, how can they create opportunities to be certain they are involved?

What should be the input of nursing into HMO development?

The participants thought it logical and necessary to deal first with general issues before identifying nursing's involvement in the development of HMOs.

HMOs - Who takes the initiative in planning?
How do you know an HMO is being planned?

Comprehensive Health Planning Organizations

Where do they get their authority and are they effective in their roles?

They may know where Health Maintenance Organizations are developing.

Do HMOs have to present a certificate of need before they can begin?

HMOs will bring a change in the economic base and roles will change.

What is comprehensive nursing care and who will be accountable for it in the HMOs, the nurse or the physician?

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Do we have the skill to teach the public how to maintain a level of wellness?

What are the measurable outcomes of nursing intervention and will the public want to buy them?

Nursing is more than a technical skill as seen by the public. We must identify the outcomes of the intangibles or the public will not be interested.

If we are to be invited to participate, we must be more politically astute. Nurses tend to become defensive and speak in behalf of the profession rather than the patient. We must be more aggressive than in the past and speak on behalf of the patient and family.

What are opportunities in health care settings to demonstrate that nursing care makes a difference?

Emergency Rooms

Clinics

Home Care

Inpatient Care

Some studies have been done to demonstrate the outcomes, i.e. Lewis-Reznick study.

We need to identify which investments in nursing give higher yields to the family. If we want resources allocated to nursing by the public, the patient or the government, we need to be economically critical of our approach to care.

Should the nurse be coordinating the patient's care?

We expect nurses to be all things to all people. This is not realistic.

In determining and marketing our role, we must identify at what level categories of decisions can be made. A nurse should be prepared to play an independent, interdependent, and dependent role with other team members.

Long-term care is a part of comprehensive health maintenance. All care systems are reluctant to absorb this problem. It should be part of the total system.

Summary:

In creating opportunities to make sure nursing is involved in the planning of HMOs.

1. Nurses must become politically aware in negotiating for participation.

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once she is invited to participate, her input should be in relation to patient care instead of the profession.

2. Nurses must be knowledgable about HMOs and other trends in health care delivery systems.

3. Nurses should inform their nursing organizations of their recommendations about health care delivery systems.

4. Nursing must be identified as a salable item with a high yield.

5. Nurses must reorient themselves to patient needs.

Nursing input in HMO development should include:

1. Nursing clinicians in primary care

2. Continuity of care

3. Staff utilization review

4. Identification of decision levels

5. Credibility of nursing

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Group III

Recorder: Lynn Westcot
Leader: Lillian Ostrand

General Question: How will the change in emphasis from in-service care to ambulatory care change the functions and roles of nurses?

I. The Role of the Nurse as Primary Care Person

A. What is involved in the expanded role of the nurse in the PMO?

1. Change in orientation from illness to wellness.

2. Accountability to the patient in terms of assessment.

3. Provision of patient support - being the patient's advocate.

4. A solid commitment to prevention.

5. A diversity of functions to fulfill the broad range of services from ambulatory to critical care.

6. A colleague relationship with physicians and others on the health care team.

B. What is needed for nurses to define and fulfill this role?

1. Agencies with strength of purpose and commitment not to let the new nurse down.

2. Administrative receptivity and support toward recommendations for changes and strength to implement them.

3. Peer support as the role is evolving.

4. Good communication with physicians so nurse has security of knowing both are telling the patient the same thing.

5. Solid background in physical, social, and biological sciences.

6. Knowledge of wellness and prevention.

7. Aggressiveness in saying and demonstrating what they can and will do.

8. Security and adequacy of performance.

9. Documentation and collection of data to describe and support functions. Need to find ways to account for hidden things of a supportive nature that are done--comforting the patient and family, listening, etc.

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10. Feedback from physicians and interdisciplinary team to permit understanding of how physicians and others on team see their roles.

II. Concerns, Problems and Needs Identified by the Group

A. Advancement of Nurses

1. Would employment within HMOs prescribe the nurses' functions and disallow for upward mobility or expansion of functions?

2. Nurses who demonstrate skills in direct patient care are too often moved up the line to administrative rather than patient care positions.

B. Licensure

1. Diversity of nursing functions in a variety of settings should continue until definitions of role are firmly established (since agencies now assume responsibility for the nurse's practice in unorthodox settings).

2. The expanded role of the nurse will involve changes in licensing and nurse practice laws.

3. Continuing education should be necessary for relicensure. Programs to provide this must be conveniently available. University-based inservice-education programs should be accelerated.

C. Students and Beginning Staff

1. Students want depth in skill--need supervision and guidance to separate what is from what is not nursing.

2. There is disenchantment of younger nurses with the status quo. Younger nurses are demanding innovations. They don't understand or tolerate fragmentation.

3. At the same time there is insecurity resulting from the threats of a first job vs. ideals of new learning.

D. Physicians

1. The physician is an expert in his field. Nurses should not put all their energies into the development of technical skills.

2. Physicians are often threatened by nurses' abilities (until nurses demonstrate what they do for rather than to patients they will not be co-workers with physicians).

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E. Consumers

1. The patient as consumer is not always adequately informed as to what nurse's role is.

2. Can the consumer evaluate good quality care? Maybe not, but he can recognize poor quality.

F. Nursing

1. If the nurse fails to use her knowledge and to accept responsibility for nursing intervention, she will relinquish it to lesser prepared people.

2. Nurses need to give much thought to defining what they do. Everyone else has his ideas about nursing which tend to define the role, if nursing doesn't.

3. Not enough nurses are doing research or are analyzing what they are doing and why.

4. There are available models for teams which include nursing input. Example: Medicare Certification Utilization Review - Nursing contributes recommendations and works with all other health-oriented disciplines--makes valued judgments which are accepted by the group.

III. Problem Solving

A. The Problem: The potential exists for a misinterpretation of the HMO concept as solely as prepaid insurance plan with emphasis on illness to the exclusion of health maintenance and preventive aspects of care. An additional problem may exist when nurse manpower is either underused or misused in the HMO and physicians adhere to functions of a traditional clinic or outpatient service under the guise of an HMO. How can nursing education gain appropriate HMO practice fields for nursing students?

B. Suggestions from the Group

1. Involve the physicians - "we need your help" approach. (May say we need an expanded program for students.)

2. May be helpful to gain support from maverick-type physician in the program--one not committed to traditional nurse utilization. Point out that other successful programs are doing great deal in health supervision--interested in providing like services in this one.

3. State, "Our faculty is prepared to:"

a. assess or evaluate patients physical and health needs.

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Can do this in a variety of settings (on-the-job, in the home, in the school, well-child clinics, ante- and postpartum clinics).

b. do positive health teaching in nutrition, ADL, etc.

c. outline immunization schedules.

d. recommend screening and testing.

e. refer persons with health problems to physicians.

f. provide direct patient care of the chronically ill (teach family to give care).

4. Invite the nurses to a conference, unify them, involve all areas of service within HMO.

IV. Dr. French met briefly with the group. A member asked how to establish guidelines for nursing functions.

A. Summary of her comments.

1. There is a need for nurses to formulate objectives in behavioral terms which are measurable.

2. Nurse must know the role of the particular agency.

3. Communication is difficult within a single discipline and between different disciplines. "Talk does not always mean communicating."

4. There are gaps in good nursing care if we depend solely on what the patient wants.

5. Starting an evaluation of a service or program after the fact (without collection of base-line data) is generally of little value. Collection of data must start prior to the study.

6. Get peer support in dealing with new individuals and/or group.

7. No one component of nursing is unique-uniqueness lies in the "collage of nursing." From time to time the collage has to change.

8. State agencies have an obligation to provide consultant service and support nursing in areas where HMOs are established.

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Group IV

Recorder: Elizabeth Zenz
Leader: Ruth Anne Yauger

Major discussion points have been arbitrarily divided into (1) Concerns and Beliefs - Nursing Education; (2) Concerns and Beliefs - Nursing Service; (3) Nursing Role - Service; (4) Education - Role; (5) Developing Nursing Input in HMOs; and (6) Recap of shared concerns and beliefs.

We found it important to identify "where" we are and "why," before moving into the future. You will note that many of our concerns are posed in the form of questions.

I. CONCERNS AND BELIEFS - Nursing Education

A. What does the consumer want?

B. Are nurses "staying away" from ambulatory patients because they aren't comfortable or unable to cope?

C. It seems that many programs are preparing students (primarily) to pass.

D. There is great need for more articulate less submissive nurses.

E. What are the real legal barriers to expanding the role of the nurse? Could it be that nursing has spent more time and energy in defining and defending its parameters of practice than in broadening them?

F. Agency policies may be more important in identifying roles and functions than education and law.

G. Practice statements issuing from state nursing profession "Councils on Practice" are helpful if uniformly interpreted and used.

H. Changes in practice are followed by changes in education and law.

I. Change can be accelerated through in-hours staff development programs - if the environment is right, all things considered.

J. Need to identify more realistic and better defined expectations of practitioners.

K. Why is nursing so often by-passed in State Boards? State Boards, NLN, etc. must assume responsibility for keeping pace with changes in testing for knowledge.

L. Does licensing protect the consumer or the profession?

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M. Content for both episodic and distributive patterns of nursing care should be offered in one program.

N. Practice in a different setting can motivate nurses to practice with heretofore unidentified enthusiasm, competence and professionalism.

O. Education needs to put instructors in clinical settings and involve service people in curriculum review and evaluation.

II. CONCERNS AND BELIEFS - Nursing Service

A. The concept "health team" is a myth with our present methods of financing and physician control.

B. There is neither a shortage or surplus of nurses - they just don't want to work where the need is - and/or are being inappropriately used.

C. What does the consumer want? planning, changing, etc.?

D. There is possible dilution of muscle and visibility with loss of an identified Division of Nursing. However, with the potential complexity and comprehensiveness of HMO in providing care, we would challenge the suggestion that HMO might affect present organizational patterns if same are functioning effectively and efficiently, and can prove it.

III. ROLE - Nursing Service

A. A division of opinion existed

1. Nursing must create its special role in HMO.

2. Nursing in HMO no different from other practice settings, but we must first define nursing and get back to using nurses as nurses.

B. Provision of primary, maintenance and preventive levels of health care in a broad variety of settings and in collaboration with a vareity of other disciplines.

C. Additional roles inherent in (b)--ombudsman, advocate, observer, communicator, listener, teacher, initiator.

IV. ROLE - Nursing Education

A. Add physical assessment/diagnosis skills to curriculum.

B. Place more emphasis in theory and practice on wellness, and ambulatory and home care.

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C. Add emphasis on skills of observing, communicating, teaching, and advocating.

D. Teach more real concern for expressed problems and concerns of consumer.

E. Provide a more realistic practical learning experience, including priorities, pressures, and real live "like it is" situations.

V. DEVELOPING NURSING INPUT IN HMO

A. Identify and evaluate present HMO nursing roles and functioning and impact. Identify what could be changed to maximize nursing contribution and how--and with what predictable outcomes.

B. Must keep informed regarding HMO developments to be able to make a contribution to planning, implementation, and evaluation.

C. Active involvement is possible through membership and participation in planning councils, already organized channels (ANA, NLN - etc.), individual or small group endeavors, by proving ability to do the job.

D. Need creative concrete ideas regarding nursing role in HMO--use of demonstration projects.

E. Critical need to disseminate information regarding HMOs--in a planned way. How? Meetings, articles workshops?

VI. RECAP OF SHARED CONCERNS AND BELIEFS

A. Continuing need to establish career ladders (or lattices, as you will) so that no job (or special training for a role) becomes a dead end proposition.

B. Possibility of joining forces with other professional groups lower on the status pole (than physicians, pharmacists, social workers, dentists) in developing and implementing health care roles in HMOs.

C. Need for a colleague-type relation with physicians.

D. Need for support for people with new ideas which confront or attach the system/establishment. There are entirely too many obstacles standing in the way.

E. Perhaps women's lib or the rising number of male R.N.s will help to change present male (M.D.) dominance of our female profession.

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F. Whole image of nursing needs to be changed so we can take care of the sick, one-half sick, and well!

G. The target population of HMOs will be well defined and accessible to health care givers. This opportunity may eventually reinforce our teaching role and even make it possible to extend home health services to populations without it (because of physician resistance).

H. Great need for more nurse manpower prepared at Master's level to meet expectations and needs. Present employer expectations for Baccalaureate product may be unreasonable.

I. Great need for research to determine how we nurses make a difference--to whom and under what circumstances--both for more efficient and effective delivery of services to consumers and use of manpower. Presented in the right way to the right people, facts (not feelings) will take us almost anywhere we want to go.

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Group V

Recorder: Phyllis Townsend
Leader: Vernice Ferguson

This group expressed general agreement that developing Health Maintenance Organizations could offer nurses a unique opportunity to affect the delivery of health care in a positive way despite the very real deficiencies noted in the models of HMOs now operating. The focus of discussion was on strategies by which our impact could be realized. Two significant points of influence were identified:

1. At the time when an HMO is forming, there should be active involvement of nurses, both as citizens and nurses. Committee work, journalistic efforts through press releases, telling our story to organizations, legislators and attendance at public hearings were cited as necessary. The consumer, the legislator and other professionals need to be informed and influenced.

2. The need to develop new role models in nursing through demonstrated competence. In Health Maintenance Organizations the nurse can function as primary assessor of patient status and as a knowledgable practitioner, make referrals as necessary. An example of this new role is the pediatric nurse associate who carries her own case load and is a colleague of the pediatrician.

In consideration of such strategies, group members devoted much time to areas of concern in the educational preparation of the student for nursing practice. In addition, examining the viability of nursing as a profession posed some difficulty as we attempted to identify nursing's unique contribution to society. Is the maternal, caring instinct an important characteristic? If so, why then recruit males? Is nursing's versatility the selling point? Yet in an era of specialization with knowledge expanding at such a phenomenal rate, is this versatility desirable, much less realistic?

Some of the group's concerns were posed in questions:

1. To what degree are Health Maintenance Organizations a "political football"?

2. Do we accept the HMO concept as evident in the existing models?

3. What refinements are needed?

4. Should there be professional autonomy or should an interdisciplinary team approach be adopted? Who then should lead?

5. Should we continue to prepare "generalists" or offer students in baccalaureate programs specialty options at undergraduate level? Would such preparation enable them to make a more effective and "visible" contribution in different settings?

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6. The cost of advanced education in nursing and the length of programs are almost comparable to medical programs. Does society view nursing's contribution as being in appropriate ratio to cost?

7. In the prototypes of Health Maintenance Organizations described, definite "cracks in care" are apparent. Where are the programs for the elderly, in mental health and health counseling?

Further discussion resulted in the following comments.

1. A much greater proportion of the practicum in nursing education should be in homes and community agencies rather than in hospitals.

2. Certain constraints imposed upon nursing by law may act as a deterrent to changing roles and functions.

3. The physician's assistant role introduces a new dimension to health care costs, consumer acceptability, organizational structure and control.

4. The function of nursing is essential but may be performed by others in many cases.

5. The nurse's preparation gives her versatility and the range of skills necessary for comprehensive assessment of patient status.

6. Standards of practice should be developed by nurse practitioners in conjuction with consumers. These standards should be measured in patient outcomes.

Summary

The prototypes described in the first day of the conference although exciting, appear to be prepaid group health care plans with the physician in the ascendant role. It is recognized, however, that these groups are meeting some of the medical care needs or perhpas all of the health care needs of some of our citizens.

Nursing must participate in the planning, delivery and evaluative stages of developing HMOs. Nursing's uniqueness may well be its versatility. The importance of the assessment function must be emphasized. Considerations relative to the cost of health care, independent nurse practice and involvement in the development of standards to measure quality health care are valuable contributions that nurses can make in the Health Maintenance Organization concept and functions.

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QUESTIONS FOR AND ANSWERS FROM GROUP WORK AS DEVELOPED BY INDIVIDUAL ENROLLEES

Question: In a rural area what should a public health nurse do to prepare herself to function effectively in an HMO before it is established?

Answer: Responses to the health needs of her community, families and patients through continuing education, in-service and/or consultation services.

Adaptable to change.

Capable to identify nursing as a salable item with a high yield.

Question: How can professional organizations (State Nurses' Association) assist nurses who become part of HMOs to assume the extended role?

Answer: First State Nurses' Associations will have to look at what they believe the "extended role" of the nurse should be. Do they want to assume the "extended role" or will nurses become physician's assistants or hand their responsibilities over to others? After this decision is made, then something can be done to develop state wide or regional programs to update or extend the practice of the nurse.

Question: If licensure laws are to be changed or discarded, as Dr. Ellwood suggests, how can the professional organization assist or develop the criteria which is needed to evaluate quality of nursing care? What is nursing's role in helping other professions to establish their criteria for quality of patient care?

Answer: It seems to me that State Joint Committees on Practice (medicine, nursing, dental, others) must sit down together and come up with some definitions for all the roles. Then nursing must set standards not in the area of qualifications and functions, but regarding effect on patients. Then we jointly need to consider how we work together to improve quality and quantity of patient care.

Question: How will additional information regarding HMOs activities be obtained by nursing instructors; are more workshops such as this one planned for region and where, when? There seems to be a need for some information on the status of nurses in the HMOs activities.

Answer: Still unable to answer questions. Comment on the status of nurses in the HMOs activities was discussed at great length, but in my opinion it still needs clarification.

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Question: If the idea of no licensure for professional personnel becomes a reality, and the HMO is responsible for whatever practice is given to the recipients of care, how will we in nursing control the practice of those individuals who have difficulty in recognizing their own limitations?

(No answer given)

Question: How can we build into our nursing educational system the whole concept of prevention, so that we are as concerned about the individual who smokes as we are about the unimmunized baby? Until we do this, the promotion of health and prevention of disease in the HMO may be difficult to realize.

(No answer given)

Question: I do not really see where the nurse will be able to exercise upward mobility in a HMO program. Rather she will be placed in a "slot." Where will the nurses' independent judgment be recognized? (This is particularly in reference to the Puget Sound Cooperative where Physician's Assistants carried more responsibility than the nurse.) What will be the nurses' functions in an HMO?

Answer: Nurses must become active in formulating the functions of the nurse in an HMO. They need to be accountable for what they do and strive for a greater interdisciplinary approach to care given. The nurse could indeed be the primary assesser of patient's needs and therefore make independent judgments.

Question: Will the nurses need to be educated and trained in different ways to fill the role in an HMO?

Answer: Very definitely the nurse will need to be educated in different ways. Focuses must be placed on prevention ambulatory care, and community health needs.

Question: It would seem that the role of the nurse in HMOs should be expanded from that of the traditional role. What do we envision this role and functions to be? What independent functions does she have?

Answer: From the discussions in my group as well as some of the presentations given at the conference, I would see the role of the nurse in HMOs to be that of a primary care giver. I envision her interviewing patients and their families, making assessments of their needs and referring them to the appropriate team member for care.

I believe the nurse has an independent role as well as a dependent and interdependent role. Her independent role could involve health care, preventive aspects and teaching.

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She could do some physical examinations and refer families as necessary.

Question: How can the role (expanded) of the nurse really be identified in this type of structure and how can this nurse gain recognition of her potential in such a structure as the Group Health Cooperative of Puget Sound?

Answer: I feel it will be necessary for nursing to be actively involved in initial exploration of HMO development and a vital part of the planning and organization of such systems. Unless we (nursing) do this the nurses in these programs will be expected to function in the conventional and/or traditional manner. We need some "top drawer" models and this needs publicity-both on local and regional basis as well as nationally.

Question: What type of strategy can be used to produce change in the nursing curriculum to produce a nurse? Who is concerned with and capable of delivering comprehensive care? Is this possible? Is this realistic? Just as our Health Care delivery system needs complete overhaul-doesn't our Health Care Personnel Education also need overhaul?

Answer: We must continue to communicate this need by dialogue-involvement in curricular studies, etc., the broad picture. In every possible encounter we must communicate in every possible manner to the Nurse Educators the need to assure, for students, learning experiences that emphasize wellness, health maintenance, prevention, rehabilitation-the whole concept.

Nursing can no longer be illness and hospital oriented. I personally am making this one of my priority concerns. Am meeting with our Area Health Planning Council next week to discuss same.

If our schools really did follow-up studies (meaningful ones) on our graduates, would this need for curricular change not be strongly evident?

Question: How can an HMO in a large urban area meet accessibility needs-i.e., group enrollments of large industrial groups close to the HMO facility will be drawing on workers who commute for miles. Their families, injured at home will lose in terms of continuity of care. They will probably go to the nearest emergency facility for care and receive general health maintenance and diagnostic care from the HMO facility. What can be done to resolve the geography problem and hopefully maintain some manner of continuity?

(No answer given)

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Question: What responsibility should the professional nurses assume to assure HMO participants: (a) do not feel they are getting assembly-line care? (b) receive adequate health education and health teaching? (c) have continuity of nursing care between all health care points (i.e., public health agencies, school, industry, family planning, etc., etc.)?

(No answer given)

Question: How can a multidisciplinary team effort be insured in the development of HMOs?

Answer: As a result of group discussion the following recommendations resulted.

1. Improve interpretation of nursing role to physicians.

2. Insure through Health Planning Organizations and state nursing organizations the involvement of nursing in planning HMO.

3. Once involved in planning, roles should be described in terms of patient and family benefit rather than professional advancement.

4. Objective data should be collected so that nursing and other professionals can demonstrate their value to patient and family health maintenance.

Question: How can the nursing profession bring about change in the concept of the nurses' role in an HMO, that is to have her utilized for her capabilities? (Nurses do not seem to have a voice in the roles they are placed, therefore are continuing to be used in the old conventional ways.) How can we actually become part of the planning?

Answer: By being involved with her professional organization, community affairs, and state legislation. Regional Planning Committees may have knowledge of some HMOs being planned. The nurse will need to seek others--not wait for them to ask her to be involved.

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